



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

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.

Type of License: [X] Initial Full License [] Administrative License [] Volunteer License

Check One: [X] U.S./Canadian Graduate [] International Graduate

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

Ree Andrea Hsu
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

[X] M.D. [] D.O. [] PhD [] Other degree [] Male [X] Female

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

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

Social Security Number: Date of Birth: Month Day Year

NPI (National Provider Identifier) Number: 1417249665

Place of Birth: New York City NY
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: Telephone: 617 417 2394
Number and Street
Philadelphia PA 19104
City State/Province/Territory Zip (or postal) Code

E-mail Address: Fax number:

Are you applying for licensure through FCVS? [] Yes [X] No

* The Board will use your Mailing Address for all correspondence

Pre-medical School

		<u>From</u>	<u>To</u>
Name: <u>Harvard College</u>	Degree: <u>BA</u>	Year: <u>1999</u>	Year: <u>2003</u>
Street: <u>20 Garden St</u>	City: <u>Cambridge</u>	State: <u>MA</u>	
Name: <u>Harvard Extension School</u>	Degree: <u>none</u>	Year: <u>2000</u>	Year: <u>2002</u>
Street: <u>51 Brattle St</u>	City: <u>Cambridge</u>	State: <u>MA</u>	

Medical School

Name: University of Pennsylvania School of Medicine Degree: MD
Street: 3620 Hamilton Walk City: Philadelphia State: PA
Name: _____ Degree: _____
Street: _____ City: _____ State: _____

Medical School Graduation Date: 6 / 2011
Month Year

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. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

		<u>From</u>	<u>To</u>
Facility: <u>Hospital at the University of Penn</u>	PGY Year: <u>1-4</u>	<u>6 / 2011</u>	<u>6 / 2015</u>
Specialty: <u>Obstetrics and Gynecology</u>	City: <u>Philadelphia</u>	State: <u>PA</u>	
Facility: _____	PGY Year: _____	____ / ____	____ / ____
Specialty: _____	City: _____	State: _____	
Facility: _____	PGY Year: _____	____ / ____	____ / ____
Specialty: _____	City: _____	State: _____	
Facility: _____	PGY Year: _____	____ / ____	____ / ____
Specialty: _____	City: _____	State: _____	

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. 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, FLEX, COMVEX, COMLEX or a state examination). If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

<u>Examination</u>	<u>Number of attempts</u>	<u>Passed (P) or Failed (F)</u>	
USMLE Step I	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step II	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step III	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
NBME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 1		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 2		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Pre-1985		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 1		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 2		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 3		<input type="checkbox"/> P	<input type="checkbox"/> F
COMVEX		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Single		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
State Board Exam		<input type="checkbox"/> P	<input type="checkbox"/> F
	(State of examination and year)		

Hospital Affiliations and Employment

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

		<u>From</u>	<u>To</u>
Facility:	<u>Hospital of the University of Penn</u>	<u>6 / 2011</u>	<u>6 / 2015</u>
Street:	<u>3400 Spruce St</u>	City: <u>Philadelphia</u>	State: <u>PA</u>
Facility:	_____	_____/_____/____	_____/_____/____
Street:	_____	City: _____	State: _____
Facility:	_____	_____/_____/____	_____/_____/____
Street:	_____	City: _____	State: _____
Facility:	_____	_____/_____/____	_____/_____/____
Street:	_____	City: _____	State: _____

- List other states (abbreviations) where you are currently or have ever had a full license: _____
- 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
- List Board Certification(s): _____

- List your practice specialt(ies) Obstetrics and gynecology
- Have you completed the Opioid and Pain Management training? (See Full Instructions, page 4.) Yes No
- Reason for requesting a Massachusetts medical license: Family Planning fellowship at
Brigham and Women's Hospital, start date 7/1/15
- Name of Facility: Brigham and Women's Hospital
Address: 75 Francis St City: Boston
- Anticipated starting date in Massachusetts: 7 / 1 / 15
- Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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.

Andrea Roe
Signature of Applicant

12 / 7 / 2014
Month Day Year

Andrea Hsu Roe

CLINICAL TRAINING

Brigham and Women's Hospital 7/15-present
Fellow in Family Planning

Hospital of the University of Pennsylvania 6/11-6/15
Resident Physician in Obstetrics and Gynecology
Co-administrative chief, 2014-2015. Labor floor nurse-physician liaison. Resident reporter at the 2013 meeting of the American Society of Reproductive Medicine.

EDUCATION

Harvard School of Public Health 7/15-present
Master of Public Health Candidate

University of Pennsylvania School of Medicine 8/07-5/11
Doctor of Medicine
Co-president of the Ob/Gyn Interest Group. Co-president of Medical Students for Choice, Penn chapter. Head of the Unity Clinic, a volunteer clinic for an underserved Asian population in South Philadelphia. Elizabeth Blackwell Society mentor.

Harvard College 9/99-6/03
Bachelor of Arts in History and Science
Honors thesis entitled "From Progesterone to Prozac: The PMS Diagnosis in the Twentieth Century." Certificate in Mind, Brain, and Behavior. Citation in French Language. Board member of the Mental Health Awareness and Advocacy Group.

Horace Mann School 9/94-6/98

HONORS

Obstetrics and Gynecology Residency Award for Excellence in Medical Student Teaching 6/13
Focus Medical Student Fellowship in Women's Health, University of Pennsylvania School of Medicine 9/10
E. Marshall Harvey Scholarship, University of Pennsylvania School of Medicine 9/09-5/11
Meredith Scholarship, University of Pennsylvania School of Medicine 9/07-5/09
Magna cum laude, Harvard College 6/03
John Harvard Scholarship, Harvard College 6/03
McLean Hospital Stanley Research Scholarship 6/03

PROFESSIONAL ORGANIZATIONS

American Congress of Obstetricians and Gynecologists 6/11-present

WORK EXPERIENCE

Planned Parenthood League of Massachusetts 8/06-8/07
Gynecology Clinic Assistant

Harvard Medical School/Massachusetts Mental Health Center 9/03-6/06
Psychiatry Research Assistant

Andrea Hsu Roe

Page 2

RESEARCH

Current Research

Reproductive health in women with cystic fibrosis. Faculty mentor: Courtney Schreiber, MD, MPH. IRB-approved survey of reproductive and contraceptive practices in a cohort of female cystic fibrosis patients.

The quantity and quality of cervical mucus among women with cystic fibrosis. Faculty mentor: Courtney Schreiber, MD, MPH. IRB-approved human subjects research.

Roe AH, Traxler S, Schreiber CA. Contraception in women with cystic fibrosis: a systematic review of the literature. Submitted to *Contraception*.

Research Publications, Peer-Reviewed

Roe AH, Hillman J, Butts S, Smith M, Rader D, Playford M, Mehta NN, Dokras A. "Decreased cholesterol efflux capacity and atherogenic lipid profile in young women with PCOS." *Journal of Clinical Endocrinology and Metabolism*. 2014 May; 99(5): E841-7.

Roe AH, Prochaska E, Smith M, Sammel M, Dokras A. "Using the Androgen Excess-PCOS Society criteria to diagnose polycystic ovary syndrome and the risk of metabolic syndrome in adolescents." *Journal of Pediatrics*. 2013 May; 162(5): 937-41.

Chavkin DE, Molinaro TA, Roe AH, Sammel MD, Dokras A. "Donor sperm insemination cycles: are two inseminations better than one?" *Journal of Andrology*; 2012 May-Jun; 33(3): 375-80.

Stone WS, Roe AH, Faraone SV, Tsuang MT, Seidman LJ (2005). "The Consortium on the Genetics of Schizophrenia (COGS): Preliminary findings of impaired learning and memory on the California Verbal Learning Test, Second Edition (CVLT-II) in subjects with schizophrenia and their relatives in a multisite study." *Schizophrenia Bulletin*, 31(2): 344-5.

Other Publications

Roe AH, Dokras A. "The diagnosis of PCOS in adolescents." *Reviews in Obstetrics and Gynecology*. 2011 Summer; 4(2): 45-51.

Stone WS, Roe AH, Tsuang MT (2005). "Overlapping of the spectra: Physical comorbidity between schizophrenia and affective disorders." *The Overlap of Affective and Schizophrenic Spectra*. Eds. Marneros A and Akiskal H. Cambridge: Cambridge University Press, 2007. 207-223.

LANGUAGES

French (fluent), Spanish (basic), and Mandarin Chinese (basic).

INTERESTS

Art history, French language and literature, and travel.

PRINT NAME: Andreea Roe DATE: 12 / 7 / 14

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS

YES NO

1. While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)
- 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 been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?
5. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?
6. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)
7. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?
- 8-A. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?
- 8-B. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)

PRINT NAME: Andrea Roe

DATE: 12 / 7 / 14

YES NO

- 9-A. Have you ever relinquished any medical staff membership or association with a health care facility?
- 9-B. Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever 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, administration or governing board?
- 9-C. Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?
10. Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)
11. Has your privilege to manufacture, distribute, administer, 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 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 had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?
- 14-A. Has any medical malpractice claim ever 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?
- 14-B. Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?

PRINT NAME: Andra Roe DATE: 12 / 7 / 14

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (Note: Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (Note: This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: Andra Roe Date: 12 / 7 / 14

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

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. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

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

Applicant's Signature: Audrea Roe Date of Birth: _____

Print or Type Name: Roe HT U.S. Social Security No: _____
(Last Name) (First Name) (Middle Initial)

Other Name(s): _____
(Please type or print.)

Name of Medical School: University of Pennsylvania School of Medicine

Address: 3620 Hamilton Walk City: Philadelphia State or Province: PA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above-named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

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: Harvard College, Harvard Extension School

Undergraduate School Address: 20 Garden St, 91 Brattle St - Cambridge, MA 02138

Enrollment and Participation: Our records indicate that Roe (Last Name) Andrea (First Name) H (Middle Initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
<u>8/6/07</u>	<u>6/23/08</u>	<u>8/25/08</u>	<u>8/30/09</u>	
<u>8/31/09</u>	<u>8/29/10</u>	<u>8/30/10</u>	<u>5/16/11</u>	
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>

Graduation Date (month/year): May 12 2011 of 3/12/11

The applicant attended 161 total weeks or total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

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. Was the medical school training more than four (4) years for U.S. graduates or six (6) years for international medical graduates?
2. Did the applicant take any leaves of absence (i.e., for research, public service, participation in an elderly care program, or for any "personal reasons")? 2/12
3. Was the applicant ever placed on probation?
4. Was the applicant ever disciplined or under investigation?
5. Were any negative reports ever filed by instructors regarding the applicant?

DATE: INITIALS:

Please provide a detailed explanation if you answered "YES" to any of the above questions.

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: Helene Weinberg
Print Name: Helene Weinberg
Title: Registrar, Perelman SOM at the UoPenn
Date: 1/27/15 Telephone: (615) 898-4646
E-mail address: hweinber@mail.med.upenn.edu



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

Physician Name: Andrea H Roe, M.D.

License No.: 262202

Current Status: Active

License Expiration Date: 4/27/2016

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

Connors Center for Women's Health
1620 Tremont Street, OBC-3
Boston
Massachusetts - 02120
United States of America
(617) 732-4827

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	
Newton-Wellesley Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Andrea H Roe, M.D.

License No.: 262202

Planned Parenthood League of Mass.

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

- a) inpatient care 12 hrs/wk
b) outpatient care 12 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	09/01/2015	06/30/2016	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?



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

Physician Name: Andrea H Roe, M.D.

License No.: 262202

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



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

Physician Name: Andrea H Roe, M.D.

License No.: 262202

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: Andrea H Roe, M.D.

License No.: 262202

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: Andrea H Roe, M.D.

License No.: 262202

Compliance with Legal Responsibilities

Online profile:

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

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

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

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