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

Physician Registration Renewal Application

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

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

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required.

REDACTED COPY

1. Current Status: Active Registration No.: 156483 Renewal Date: 04/11/2001

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

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

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

3. A) Mailing/Business Address:
KAREN L HOUCK

B) Home Address:

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Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

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

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

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

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

c) SS#:

5. a) Name of Medical School:

b) Year Graduated: 1994 c) Degree: M.D.

School of Medicine, State Univ. of N.Y. at Buffalo

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

Code(s)	Hours per Week in Mass.	
GO	70	
OBG	0	Obstetrics and Gynecology
0		

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

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

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

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

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 1628 (AP) ☑ 100 % Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ %
Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: HOUCK LICENSE NUMBER: 156483

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☒ Letter of Credit
Name of Insurer: CRICO Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 0
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 0 hrs/wk b) inpatient care 70 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 5 %

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

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

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		☒
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		☒
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		☒
17. Have you been charged with any criminal offense, other than a minor traffic violation?		☒
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		☒
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		☒
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		☒
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		☒

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

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

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

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

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

Signature: _____ Date: 2/25/01

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

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

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

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

RECEIVED
MAR 18 1999
Board of Registration in Medicine

Registration No.: 156483 Renewal Date: 04/11/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Home Address:
KAREN L HOUCK. M.D.

B) Business Address:
MASS GENERAL HOSP OBGYN
55 FRUIT STREET
BOSTON, MA 02114

Home Phone:
Business Phone: (716) 878-7750

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

5. A) Name of Medical School:
School of Medicine, State Univ. of N.Y. at Buffalo
B) Year Graduated: 1994 C) Degree: MD

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

Code(s)	Hours per Week in Mass.
OBG	0

Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

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

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

Home:
Business: (617) 726-2429

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

Full Name of Medical School:
_____
_____

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

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

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

Code: _____ Code: _____

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

Federal (DEA) _____
Mass: _____

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

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Houck Registration Number: 156483

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 75 ✓ (AP) ✓ 5 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%

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

If 999, print name(s): _____

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

Name of Insurer: CRICO Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 0

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

1) Average weekly hours involved in: a) outpatient care 8 hrs/wk b) inpatient care 2 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

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

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

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

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

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

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

Signature: _____ Date: 3/16/99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

Application #: 156483
Date of Issue: 5/6/98

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

RECEIVED
MAR 10 1998
BOARD OF REGISTRATION IN MEDICINE

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

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

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

Houck | Karen | Leigh | |
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

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

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

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

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

Place of Birth: Buffalo | NY
City | State/Province/Territory | Country if not USA

Home Address: _____
Number and Street

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

Business Address: 219 Bryant St
Number and Street

Buffalo | NY | 14222
City | State/Province/Territory | Zip (or postal) Code

Business Telephone: (716) 878-7750 ext. _____ Home Telephone: (___) _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

DATE: 3/11/98
INITIAL: RAC
FEE: $350.00 Check

APPLICANT'S NAME: Karen Houck

Pre-medical School

			From	To
Facility: SUNY @ Buffalo	Degree: BA		8/1/82	1/15/87
Street: Amherst Campus	City: ~~Buffalo~~ Amherst	State: NY		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: SUNY @ Buffalo	Degree: MD		8/1/90	6/15/94
Street: 3435 Main St	City: Buffalo	State: NY		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 6/94

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 chronologically from medical school to the present, 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: Childrens Hospital SUNY Consortium Hosp	Position: PGY 1-4		6/22/94	6/21/98
Street: 219 Bryant St	City: Buffalo	State: NY		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

APPLICANT'S NAME: Karen Houck

Hospital Affiliations and Employment

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

		From	To
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____

1. List other states (abbreviations) where you are currently or have ever been licensed: ___ ___ ___
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): ______
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: begin fellowship in GYN oncology
6. Name of Facility: Massachusetts General Hospital
7. Address: 275 Cambridge Street City: Boston
8. Anticipated starting date in Massachusetts: 7 / 1 / 98

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

K Houck
Signature of Applicant

2/1/98
Date

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

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. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. Please return the 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, 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.

Liability Carrier: Erie County medical center - self insured
City: Buffalo State: NY (716)858-2223
Policy Number: not applicable

Liability Carrier: Buffalo General Hospital - self insured
City: Buffalo State: NY
Policy Number: not applicable (716)859-5600 risk management

Liability Carrier: Children's Hospital of Buffalo - self insured
City: Buffalo State: NY
Policy Number: not applicable (716)878-7194

Liability Carrier: Millard Fillmore Hospital self insured
City: Buffalo State: N.Y. (716)887-5000
Policy Number: not applicable

Please forward the information to the Board of Registration in Medicine at the address above.

Signed: K Hauck 3/1/98
Date

Print Name: Karen Hauck

Karen L. Houck

Education

1990 to 1994	State University of New York at Buffalo School of Medicine and Biomedical Sciences Doctor of Medicine, *Magna Cum Laude,* June 1994
Summer 1994	Georgetowne University Kennedy Institute of Ethics Intensive Bioethics Course XX
1982 to 1987	State University of New York at Buffalo School of Social Sciences B.A. in Philosophy Honor Thesis: Review of *The Encyclopedia of Bioethics*

Employment

1994 to Present	State University Of New York at Buffalo Consortium Hospitals Resident, Department of Gynecology and Obstetrics
1994 to Present	State University of New York at Buffalo School of Medicine and Biomedical Sciences Assistant Clinical Professor: Dilemmas in Clinical Medicine
1988 to 1990	Repro Health Services, Boston, MA. Medical Assistant, Counselor
1987 to 1989	Codman Square Health Center, Dorchester, MA. Family Planning Counselor
1983 to 1985	Sexuality Education Center, SUNY at Buffalo Assistant Clinical Director

Honors and Awards

1996	Felix Rutledge Fellowship in Gynecologic Oncology
1996	Louis A. and Ruth Seigel Award For Teaching Excellence
1994	Lowenstein Award for Aptitude in Obstetrics
1994	Dr. Cyrenius Chapin Award for Outstanding Achievement in Clinical Sciences
1994	Glasgow Memorial Citation for Scholastic Achievement
1994	Dean's Letter of Commendation for Academic Achievement in Year Four
1993	Cowper Scholarship in Ophthalmology
1993	Dean's Letter of Commendation for Academic Achievement in Year Three
1991	Fellowship In Medical Humanities

Grants

1996 — SUNY at Buffalo Department of Gynecology and Obstetrics
Treatments For Cervical Dysplasia and Their Effects on HPV Innoculum by PCR Testing.
Sonoda Y, **Houck K**, Marchetti D.

Sensitivity and Specificity of PCR for HPV on Cervical Swab Samples.
Houck K, Sonoda Y, Marchetti D.

1991 — Baylor University Fellowship in Medical Humanities
The Ethical and Legal Implications of Court Ordered Medical Treatment for Pregnant Women.
Houck K, and Wear S.

Publications

Peer Review

The effects of residual disease and age on survival in advanced stage ovarian cancer.
Marchetti D, **Houck K**, Lele S, Hreshchyshyn M. (In Revision)

Desmoplastic small round cell tumor of childhood: A gynecologic presentation.
Houck K, Marchetti D, Hertzog W. (In Preparation)

Surgical staging and borderline cancer of the ovary: Is it necessary?
Zuccala S, Sonoda Y, Fitzpatrick K,**Houck K**. (Submitted)

Non-Peer Review

Houck K, Marchetti D. *Pap smears and colposcopy* in M. Pietrantoni and G. Dannakas , (eds): A Practical Approach to Obstetrics and Gynecology. Mosby Yearbook, Inc. (In press)

Marchetti D, **Houck K**. *Gynecologic anatomy* in M. Pietrantoni and G. Dannakas, (eds): A Practical Approach to Obstetrics and Gynecology. Mosby Yearbook, Inc. (In press)

Review of *Ethics in Obstetrics and Gynecology* by McCullough and Chervenak.
Houck K and Wear S (In preparation)

Abstracts

Houck K, Marchetti D, Lele S, and Hreshchyshyn M. Optimizing treatment of young and elderly patients with advanced ovarian cancer. Gynecologic Oncology. 1996;60(1):154.

Presentations

August 1996	"Primary peritoneal tumors: presentation and prognosis." Roswell Park Cancer Institute Pathology Grand Rounds
October 1996	Surgical staging and borderline cancer of the ovary: Is it necessary? Zuccala S, Sonoda Y, Fitzpatrick K (presenter), **Houck K.** 37th Martin L. Stone Society Meeting, ACOG District II, New York Academy of Medicine
November 1995	Accuracy of frozen section diagnosis in borderline cancer of the ovary. Zuccala S, **Houck K.** State University of New York at Buffalo Research Forum
November 1991	The ethical and legal implications of court ordered medical treatment for pregnant women. **Houck K**, Wear S. State University of New York at Buffalo Research Forum

Committees

1994 to Present	Center for Ethics and Humanities Co- director, Executive Committee
1994 to Present	Third Year Curriculum Committee Coordinator- Dilemmas in Clinical Medicine SUNY @ Buffalo School of Medicine and Biomedical Sciences
1994 to Present	Erie County Medical Center Ethics Committee
1995 to Present	Children's Hospital Of Buffalo Ethics Committee

Memberships And Affiliations

American College of Obstetrics and Gynecology
American Medical Association
Medical Society of the State of New York
Hastings Center

Skills and Certifications

American Sign Language
Basic Life Support Instructor
Certified Family Planning Couselor

Interests — Biomedical ethics, scuba, travel

Supplement Form

Name: Karen Houck Date: 3/1/98

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

	YES	NO	
1.			Since your matriculation in college, have you been subject to any disciplinary action (see definition) at an academic institution?
2.			Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate 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:_____
4.			Since your matriculation 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 examination, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?
6-A.			Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or 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 certification 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, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
8-B.			Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

Continued on page 2

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, denied, 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 this state or any 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 an inquiry by a professional liability insurance provider?

13. Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or other third party programs?

14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

15-A. In the past ten (10) years, has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?

15-B. In the past ten 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 been settled, adjudicated or otherwise resolved?

Continued on page 3

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Massachusetts Board of Registration in Medicine.

Name of Institution: SUNY @ Buffalo Consortium - Children's Hospital

Address of institution: 219 Bryant St Dept OB/GYN Buffalo NY 14222
Street City State Zip

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registartion in Medicine at the address above. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training to the Board.

Name of Institution: State University of New York At Buffalo Graduate Medical/Dental Education Consortium

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

Enrollment and Participation: Our records indicate that Karen Houck (type or print applicant's name) participated in the following program:

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)
Residency	1	OB/GYN	6 / 20 / 94	6 / 18 / 95	yes
Residency	2	OB/GYN	6 /19 / 95	6 / 16 / 96	yes
Residency	3	OB/GYN	6 /17 / 96	6 / 22 / 97	yes
Residency	4	OB/GYN	6 /23 / 97	6 /21 / 98	Expected completion date 6/21/98
			/ /	/ /	

Continued on back

POSTGRADUATE VERIFICATION

APPLICANT'S NAME: Karen Houck

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 time of the applicant's participation, our postgraduate medical training was accredited by:

ACGME ☐ Program was not accredited

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

Signature: J. W. Choate MD

Print Name: John W. Choate, MD

Academic Title: Medical Education Director for OB/GYN

Telephone: (716) 878-7750 Date: 3 / 4 / 98

AFFIX INSTITUTIONAL SEAL HERE

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

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

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.

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 to the ***Massachusetts Board of Registration in Medicine.***

Applicant's Signature: Karen Houck (Houck) Date of Birth: _____ Social Security No: _____

Name of Medical School: SUNY @ Buffalo School of Medicine & Biomedical Science

Address: 3435 Main St. City: Buffalo State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the applicant's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) directly 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: SUNY AT BUFFALO

Undergraduate School Address: BUFFALO NY 14214

Continued on back

Enrollment and Participation: Our records indicate that

Houck, Karen L

(type/print applicant's name: last, first, middle, suffix)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/20/90	5/24/91	7/19/93	5/27/94
	8/19/91	5/29/92	/ /	/ /
	8/17/92	7/18/93	/ /	/ /

The applicant attended 4 total ~~years~~ of continuing on-campus education, not less than 32 weeks in each academic year and

check one ☑ was awarded a degree in Medicine on (month/day/year) 6/1/94

☐ 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?		

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: [signature]

Print Name: Dr. Dennis Wedler

Title: Assoc. Dean

Date: 3/5/98 Telephone: 716 829-2802