105361

Initial Medical Licensure
PERSONAL INFORMATION
06/2008 INT

STOP! Completed application and check must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number
Amt Paid $22
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):
REEVES

First name and middle name:
MATTHEW

(If applicable, please check a box and complete below) ? Complete Maiden Name OR ? Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**
CONRAD
1911 N Fort Myer Dr, Ste 900

City: Arlington
State: VA
Zip Code: 22209-1605

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

4. **Telephone (s):** Home

5. **Date of Birth:**

6. **Gender:**

7. **Race:** Multiracial applicants may select all applicable categories
Ethnicity:

8. **Social Security Number:**

For Board Use Only

License Number: D69810 BPQA School Code:
Date Issued: 10/6/09 Federation School Code:
Licensed By: Licensing Exam: USMLE

From: [redacted]
To: <bjones@dhmh.state.md.us>
Date: 7/9/2009 4:48 PM
Subject: Name

Brenda,
Thank you for calling. My full name is Matthew Fontaine Reeves but may be listed as Matthew F. Reeves or Matthew Reeves on some documents. All these names refer to me. Please let me know if you need additional information.
Sincerely,
Matt

Matthew F. Reeves, MD
July 9, 2009

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	06	99

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity:
06	99	TO	06	03	Internship & Residency in Obstetrics & Gynecology

Address: University of California, San Francisco
Dept of Obstetrics, Gynecology & Reproductive Sciences
505 Parnassus Avenue, Box 0132, San Francisco, CA 94143-0132

month	year	TO	month	year	Activity:
07	03	TO	06	04	Clinical Fellowship in Ultrasound

Address: University of California, San Francisco
Department of Radiology, Ultrasound Section
505 Parnassus Ave, Rm L378, San Francisco, CA 94143-0628

month	year	TO	month	year	Activity:
07	04	TO	06	06	Clinical Fellowship in Family Planning & Contraceptive Research

Address: University of Pittsburgh School of Medicine
Dept of Obstetrics, Gynecology & Reproductive Sciences
300 Halket Street, Pittsburgh, PA 15213-3180

month	year	TO	month	year	Activity:
07	06	TO	06	09	Assistant Professor of Obstetrics, Gynecology, and Reproductive Sciences

Address: University of Pittsburgh School of Medicine
Dept of Obstetrics, Gynecology & Reproductive Sciences
300 Halket Street, Pittsburgh, PA 15213-3180

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:

10. **MEDICAL EDUCATION: List all medical schools you have attended**

	From: MM/YY To MM/YY
Harvard Medical School	09/95 to 06/99

Medical School From Which You Received Your Medical Degree: Harvard Medical School

Name of University Affiliation (if applicable): * Harvard University

Street Address: 25 Shattuck Street, Boston, MA 02115

City: Boston **State/Province:** MA **Country of citizenship during medical education:** USA

Language(s) of Instruction: English

Type of Degree: [X] M.D. [ ] D.O. [ ] M.D./Ph.D [ ] M.B.B.S. [ ] M.B.B.Ch [ ] Other:_____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month [0 6] Day [1 0] Year [9 9]

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

if your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. [X] I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. [ ] I passed either [ ] the TOEFL **or** [ ] the ECFMG English test after December 31, 1973 **AND** I passed the [ ] TSE [ ] OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. [ ] I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? [X] NO [ ] YES If "YES," please write or call the Board for additional information.

Initial Medical Licensure
POSTGRADUATE TRAINING
06/2008 INT

Print Your Name: Matthew F. Reeves, MD, MPH Date: 6/24/09

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education ***after*** successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s 1-4	Place of Training: University of California, San Francisco		month 06 year 99 TO month 06 year 03	
	Address: 505 Parnassus Avenue, Box 0132 San Francisco, CA 94143-0132	Specialty: Ob/Gyn	Accredited by: ACGME ☒ AOA ☐ RCPSC ☐	
PG Year #s 5	Place of Training: University of California, San Francisco		month 07 year 03 TO month 06 year 04	
	Address: 505 Parnassus Avenue, Room L378 San Francisco, CA 94143-0628	Specialty: Ultrasound	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐	
PG Year #s 6-7	Place of Training: University of Pittsburgh		month 07 year 04 TO month 06 year 06	
	Address: Dept of Ob, Gyn & Repro Sciences 300 Halket Street Pittsburgh, PA 15213-3180	Specialty: Family Planning & Contraceptive Research	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐	
PG Year #s	Place of Training:		month year TO month year	
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐	
PG Year #s	Place of Training:		month year TO month year	
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐	

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Initial Medical Licensure HOSPITAL PRIVILEGES 06/2008 INT	Print Your Name: Matthew F. Reeves, MD, MPH	Date: 6/24/09

Hospital Privileges After Postgraduate Training: Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital / Complete Address	From (month / year)		TO	To (month / year)	
	month	year		month	year
Hospital: Magee-Womens Hospital	07	04	TO	06	06
Complete Address: Dept of Obstetrics, Gynecology & Reproductive Sciences, 300 Halket Street, Pittsburgh, PA 15213-3180	**Department** Ob/Gyn/RS				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
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Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				
Hospital:			TO		
Complete Address:	**Department**				

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)?

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times?

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.
IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORETHAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure

a. **State Board Examination** List state(s): _____
STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.
Send a copy ofMBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license.
NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☐ FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☒ USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)
If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and a complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board.
Call MCC at 613-521-6012 for instructions and fee information.

MARYLAND BOARD OF PHYSICIANS RECEIVED 2009 JUL -2 PM 2:

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☒ I have an application for license pending in the following states: DC, VA, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
CA	A75550			X			
HI	11957			X			
PA	MD423665	X					

(If more space is needed, please attach an additional signed and dated sheet.)

Print Your Name: Matthew F. Reeves, MD, MPH Date 6/24/09

16. Check YES or NO.

YES ☐ Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?

YES ☐ During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico or Canada?

YES ☐ Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? Am Board of Ob & Gyn Date certified 01/17/08

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. **Character and Fitness Questions** (Check either YES or NO)

Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?

Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. Refer to the document *Grounds for Board Action in Maryland* at the Board's website www.mbp.state.md.us.

Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?

Have you ever withdrawn your application for a medical license or other health professional license?

Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?

Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?

Have you commited a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?

Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.

Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?

Do you illegally use drugs?

Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?

Have you ever been named as a defendant in a medical malpractice action?

Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?

Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?

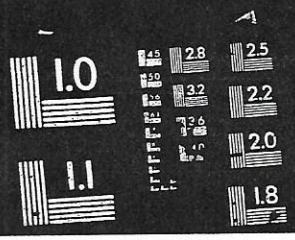
Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?

Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?

Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**



18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

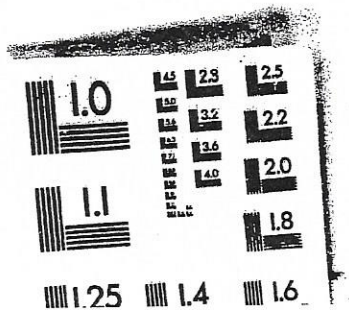
1. Total number of malpractice claims ever filed in which you were named as a defendant?

2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? __

3. Within the last 60 months (5 years) provide the following:
Total number of medical malpractice claims filed __ __; paid (settlement / judgment)
or dismissed__ __; in which you were named as a defendant.

4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

I have attached the following number of pages to this application: 0



Initial Medical Licensure Release and Certification 06/2008 INT

RELEASE AND CERTIFICATION

19. Release:
I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Matthew F. Reeves, MD, MPH — Applicant's Name (Printed)

Applicant's Signature — Date: 6/24/09

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____

Applicant's Signature — Date

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Applicant's Signature — Date: 6/24/09

22. Affidavit: To be completed by the applicantin the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Applicant's Signature — Date: 6/25/09

STATE OF Pennsylvania

CITY/COUNTY OF Allegheny

I HEREBY CERTIFY that on this 25th day of June, 2009, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Matthew F. Reeves (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Dale A Daley — Notary Public

My Commission expires: 3/21/2013

SEAL

NOTARIAL SEAL
DALE A DALEY
Notary Public
PITTSBURGH CITY, ALLEGHENY COUNTY
My Commission Expires Mar 21, 2013

STOP! Completed application and ... Board of Physicians, P.O. B...

BOARD OF PHYSICIANS RECEIVED JUL -2 PM 12:2...

Print Your Name: Matthew F. Reeves, MD, MPH Date: 6/24/09

CHECKLIST

Please review the checklist before signing page 11. A few minutes spent in review now may save days or weeks of delay in the processing your application.

[X] I have provided all the personal information requested on this application (page 1)

[X] My chronology of activities after graduating medical school is legible a

n/a [ ] (If applicable) I have enclosed additional sheets for my chronology.

[X] I have provided all the information about my medical education. (item

[X] I have indicated how I have met Maryland's requirement for English proficiency.(Item 11, page 4)

Control No: 105361 07/02/2009
Reeves, Matthew
Application Form (Standard)
Received: Vicktoria Rhoney
Analyst: Felicia Jackson

Graduates of Foreign Medical School

[ ] My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See item 11 on page 4)

I have also enclosed the following documents:

[ ] A copy of my valid ECFMG certificate (You must take the TOEFL if ECFMG English exam was before January 1, 1974)

[ ] A copy of my medical school diploma and a certified translation.

[ ] If applicable a copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

[X] I have completed Part 1 of form IML2 (follows Section V of the application) and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.

[X] I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3; signed Part 2; printed my name on side B; and sent a form IML3 to the director of each program in which I participated.

[X] I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6).

[X] I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts and any fee that may be required to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).

[X] I have listed every license/registration I have ever been issued in the U.S., its territories, Puerto Rico, or Canada.(page 8) and have sent a copy of IML7 to each medical board / issuing authority.

[X] I do not have to take the Special Purpose Exam (page 9) [ ] I must take the SPEX and have made arrangements to do so.

[X] I have answered all character and fitness questions (page 9), explained all "yes" answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)

[X] I have attached a 2"x 2" passport quality photograph to the last page (page 11) of this application.

[X] I have read the statements on page 11 of this application; signed and dated items19, 20 (if applicable), 21 and 22; and arranged to have the application notarized.

[X] I have enclosed my check made out to "Maryland Board of Physicians" (or "MBP") in the amount of either $822.00 (Graduates of LCME-accredited American and Canadian medical schools) or $922.00 (Graduates of International Medical Schools).

[X] I have attached the following number of pages of documentation to support this application: 1 (coverletter)
(All supporting documentation will be mailed directly)

[X] I have signed the application in the presence of a notary and had the application notarized.

MARYLAND BOARD OF PHYSICIANS RECEIVED JUL - 2009

STOP! Completed application and check must be mailed to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297.

MARYLAND BOARD OF PHYSICIANS
4201 PATTERSON AVENUE, P.O. BOX 2571
BALTIMORE, MD 21215-0095

REQUEST FOR PRIMARY SOURCE VERIFICATION

Assigned analyst: **Felicia Jackson**

Date of Request: **07/02/2009**

Physician's Name:

Last: **Reeves**

First: **Matthew**

Middle:

Maiden/Former:

Date of Birth:

Social Security Number:

School of Graduation: **Harvard Medical School**

City: **Boston** State: **MA** Country: **USA**

Date of Graduation: **1999** Degree Received: **M.D.**

****

VERIFICATION

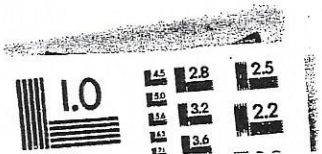
Verifier: Debbie Fitzgerald Date of Verification: 07/06/2009

Confirmed Above information: ✓ Yes ___ No School, degree & date noted above are correct.

Contact Person: Debbie Fitzgerald Contact Telephone #: 6174321515

Note Changes to Information/Remarks:

March 21, 2002



Initial Medical Licensure
Supplemental Form
MBP IML2 ,
06/2008 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ¦ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1 APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask them to return the completed form directly to the Board.

Name: REEVES (Print last name and generational indicator (Jr., Sr., II, III, etc.)) MATTHEW (First name) FONTAINE (Middle name)

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

School Attended Harvard Medical School
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): Harvard University
Name of institution that conferred your degree, if different from medical college attended

Attended from: 09/95 **to** 06/99 **Date of Graduation:** 6/10/99

Part 2 REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates from

Month 09 Day 05 Year 95 to Month 06 Day 10 Year 99 ; that all academic studies were taught in the language(s) of English ; that all clinical clerkships were taught in the language(s) of English ; and that he/she was conferred the degree of

[X] M.D. [ ] D.O. [ ] M.D./Ph.D [ ] M.B.B.S. [ ] M.B.B.Ch [ ] Other: (specify)

on Month 06 Day 10 Year 99 after he/she had satisfied all prerequisite obligations.

MARYLAND BOARD OF PHYSICIANS RECEIVED JUN 29 PM 4:13

Terese Galuszka — Printed Name of Authorized Official
Harvard Medical School — Name of Institution
Registrar — Title of Authorized Official
617-432-1515 — Telephone Number
617-432-0275 — Fax Number
Terese Galuszka — Signature of Authorized Official
June 26, 2009 — Date

SEAL OF THE INSTITUTION

Back to Search Results

PROGRAM SEARCH - VIEW PROGRAM

PROGRAM INFORMATION

University of California (San Francisco) Program [2200521047]

University of California (San Francisco)
Dept of Obstetrics-Gynecology
505 Parnassus Ave, Box 0132, M-1483
San Francisco, California 94143

http://www.obgyn.ucsf.edu

Sponsoring Institution: University of California (San Francisco) School of Medicine
Specialty: Obstetrics and Gynecology

DIRECTOR INFORMATION

Amy M. Autry, MD
Program Director
Director First Appointed: July 1, 2007
Phone: (415) 476-5192
Fax: (415) 476-1811
Email: schulerv@obgyn.ucsf.edu

COORDINATOR INFORMATION

Laura Pliska
Program Manager

Phone: (415) 476-5192
Email: pliskal@obgyn.ucsf.edu

7/9/09 fr 01-02 BAG

ACCREDITATION AND GENERAL INFORMATION

Original Accreditation Date: November 5, 1952
Accreditation Status: Continued Accreditation
Accreditation Effective Date: January 18, 2007
Accredited Program Length: 4 years

Program Format: Standard

Last Site Visit Date: November 13, 2006
Cycle Length: 3 years
Approximate Date of Next Site Visit: January 1, 2010

Program Requires Prior or Additional GME Training: NO
Program Requires Dedicated Research Year: NO
Government Affiliation: No Military or Government Affiliation

ACGME APPROVED POSITIONS

Year 1 Positions: 9
Year 2 Positions: 9
Year 3 Positions: 9
Year 4 Positions: 9
Total ACGME Approved Positions: 36

ACGME FILLED POSITIONS (CATEGORICAL AND PRELIMINARY POSITIONS ONLY)

Year 1 Filled Positions: 8
Year 2 Filled Positions: 8
Year 3 Filled Positions: 8
Year 4 Filled Positions: 8
Total Number of Filled Positions: 32

PARTICIPATING INSTITUTIONS AND ROTATIONS

UCSF and Mount Zion Medical Centers - Participating Institution
Type of Rotation: Required & Elective
Year 1 Months of Rotation: 6.9
Year 2 Months of Rotation: 7.5
Year 3 Months of Rotation: 4.5
Year 4 Months of Rotation: 5

San Francisco General Hospital Medical Center - Participating Institution
Type of Rotation: Required & Elective
Year 1 Months of Rotation: 5.1
Year 2 Months of Rotation: 4.5
Year 3 Months of Rotation: 3.5
Year 4 Months of Rotation: 6

California Pacific Medical Center - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:

Year 2 Months of Rotation:
Year 3 Months of Rotation:
Year 4 Months of Rotation: 1

Kaiser Foundation Hospital (Moanalua) - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation: 1.5
Year 4 Months of Rotation:

Kaiser Permanente Medical Center (Walnut Creek) - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation: 1.5
Year 4 Months of Rotation:

Alta Bates Medical Center - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation: 1
Year 4 Months of Rotation:

COMMENTS

STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944

www.mbc.ca.gov

June 26, 2009

MARYLAND BOARD OF PHYSICIANS
4201 PATTERSON AVE 3RD FL
BALTIMORE MD 21215-0095

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	MATTHEW FONTAINE REEVES
License No.:	A 7555[illegible]
Issued:	June 29, 2001
Exam Type:	A written examination
Expiration Date:	September 30, 2004
Status:	Delinquent
Board Discipline:	NO

MARYLAND BOARD OF PHYSICIANS
RECEIVED
2009 JUL -6 PM 12:34

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Deborah Pellegrini

Deborah Pellegrini
Chief of Licensing

SEAL

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
P.O. BOX 3469
HONOLULU, HAWAII 96801

06/29/09

MARYLAND BOARD OF PHYSICIANS
4201 PATTERSON AVE
BALTIMORE MD 21215

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 06/30/09 FOR
MATTHEW F REEVES

BOARD/COMMISSION: HAWAII MEDICAL BOARD
LICENSE TYPE: PHYSICIAN
LICENSE IDENTIFICATION: MD 11957
METHOD OF LICENSURE: PASSED USMLE
DATE LICENSED: 04/17/02
LICENSE STATUS: TERMINATED; NEEDS TO REAPPLY
LICENSE EXPIRATION DATE: 01/31/04
DISCIPLINARY ACTION: NONE

ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

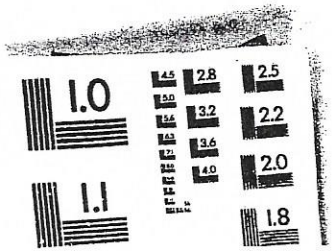
✓ NO DEROGATORY INFORMATION IS ON FILE.

— THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

Constance A. Cabral

CONSTANCE CABRAL
EXECUTIVE OFFICER



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

June 23, 2009

CERTIFICATION OF LICENSE

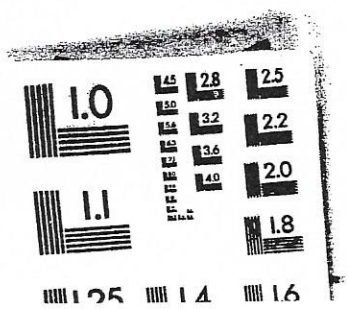
This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	MATTHEW FONTAINE REEVES
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD423665
ORIGINAL LICENSURE DATE:	05/05/2004
EXPIRATION DATE:	12/31/2010
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Basil L. Merenda
Commissioner
Bureau of Professional and Occupational Affairs



Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0069810** Dr. Matthew Reeves

2. Individual National Provider Identifier NPI: 1477528966 ☐ I do not have an NPI or I cannot find my NPI
This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)

Search NPI: https://npiregistry.cms.hhs.gov/

3a. OFFICIAL EMAIL ADDRESS: Please enter your most current email address where we may contact you regarding your license.

3b. ALTERNATE EMAIL ADDRESS: If you have more than one email address, you may enter it here. If you do not have another email, enter the same email address from 3a.

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2017. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4**a. Non-Public Address**: This address is for Board use only and is **printed on your license**. However, if no public address is listed, this address will also be made available to the public.

Street
Street (2)
Street (3)
City
State "Foreign" as your state
ZipCode
Country

4**b. Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street	1120 19th Street NW, Suite 316
Street (2)	
Street (3)	
City	Washington
State	District of Columbia If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	20036
Country	United States

Maryland Hospital Privilege Information
Hospitals are no longer required to report privileges to the Board. Physicians must maintain their own hospital privileges within their Profile, if they maintain privileges.

Please review and make any necessary updates. This will display on the Maryland Hospital Privilege section of your Physician Profile. *If you do not have hospital privileges, you can skip this question.*

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2015. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

a. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, denied your application for licensure, reinstatement, or renewal?

b. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.

c. Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?

d. Have you withdrawn your application for a medical license or other health professional license?

e. Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?

f. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for privileges, or failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

g. Have you pleaded guilty or nolo contendere to any criminal charge, or have you been convicted of a crime or placed on probation before judgment because of a criminal charge?

h. Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.

i. Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?

j. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

k. Have any malpractice claims or other claims for money damages been filed against you? Include past claims as well any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.

l. Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?

m. Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?

n. Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration been terminated for disciplinary reasons?

o. Have you voluntarily resigned or terminated a contract from any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?

p. Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?

q. Since your last renewal, have you been discharged from any military service of the U.S. Government? If so, submit a copy of your military discharge documentation to the Board that includes type of service, date of discharge, type of discharge. You may fax to 410-358-1298 or email to mdh.mbprenewal@maryland.gov.

CONTINUING MEDICAL EDUCATION (Question 7)

(●) **a. CME met ***. I have earned at least 50 credit hours of Category I continuing medical education (CME) during the 2-year period preceding the expiration of the license.

( ) **b. First Renewal & NPO**. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. See New Physician Orientation Program web site. **The Board will not renew your license unless you have completed the orientation.**

** The Board may impose a fine of up to $100 per CME credit for failure to obtain the required CME credits.*

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

[ ] American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

[ ] Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

[ ] Black or African American (A person having origins in any of the black racial groups of Africa.)

[ ] Native Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

[ ] White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

[ ] Other

9a. Are you employed by the Federal Government?

○ Yes ◉ No

9b. Do you maintain medical professional liability insurance (malpractice)?

◉ Yes ○ No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer **Yes** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

Self-Designated Practice Area

11a. Which best describes your current area(s) of concentration:
Please review and make any necessary updates. This will display on the Self-Designated Practice Area section of your Physician Profile. *If you'd prefer to leave this section blank on your Profile, you can skip this question.*

SPECIALTY BOARD CERTIFICATION:

11b. Select specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
Please review and make any necessary updates. This will display on the Specialty Board Certification section of your Physician Profile. *If you'd prefer to leave this section blank on your Profile, you can skip this question.*

ID	Specialty Board Certification
30	Obstetrics & Gynecology

Other States Licensed

12. Please select all states (excluding Maryland) where you hold a medical license.
Please review and make any necessary updates. This will display on the Specialty Board Certification section of your Physician Profile. *If you'd prefer to leave this section blank on your Profile, you can skip this question.*

ID	Other States Licensed
VA	Virginia
DC	District of Columbia

13a. How many weeks per year do you work? 50

13b. Please indicate below how the hours are allocated in your typical work week . The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes the teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	8	hours per week
b. Research	2	hours per week
c. Teaching	4	hours per week
d. Administration & Other	32	hours per week
Total Hours	46	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next two years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 1

If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

◉ Yes ○ No ○ Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 3

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: DuPont Clinic

Organization Name2: DuPont Clinic

b. Street Address: 1120 19th Street NW, Suite 316

c. Street2:

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Washington

e. State: District of Columbia

f. Zip Code: 20036

g. Jurisdiction: Non-Maryland

h. Employer Tax ID

If you do not have an EIN enter 00-0000000

What is Employer tax ID?

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter > Organizational NPI

◉ I use my Individual NPI for billing.

○ I do not bill public or private insurers.

○ I can not find my Organizational NPI.

---

j. You indicated in Question 13a, 8 hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 8 Hours
If none, enter 0.

---

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Solo-independent

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 1

Number of mid-level medical providers at this location. 2

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

---

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: FemHealth USA, Inc.

Organization Name2: carafem

b. Street Address: 5530 Wisconsin Ave, , MD 20815

c. Street2: Suite 1200
Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Chevy Chase

e. State: Maryland

f. Zip Code: 20815

g. Jurisdiction: MONTGOMERY

---

h. Employer Tax ID
If you do not have an EIN enter 00-0000000
What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter > Organizational NPI

○ I use my Individual NPI for billing.

○ I do not bill public or private insurers.

◉ I can not find my Organizational NPI.

---

j. You indicated in Question 13a, 8 hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at 8 Hours

this practice/office location?
If none, enter 0.

k. Setting: Free Standing Medical Facility

l. Private/Public: Private-Not for profit

m. Practice: Other Contractual-Associate Staff (Individual only)

20-21 The Health Information Technology questions have been moved to a separate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ○ Yes ◉ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ○ Yes ◉ No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ○ Yes ○ No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ○ Yes ◉ No

c1. If **Yes**, are you accepting new Medicare patients? ○ Yes ○ No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)
○ Yes ◉ No ○ N/A

23a. Do you participate in a value-based payment program?
○ Yes ◉ No

23b. ***If YES***, please indicate what type of value-based payment program model you predominately participate in by selecting from the list below:

Select type of value-based payment program model

23c. ***If either ACO model was selected from the list above***, please indicate which ACO you predominately participate with by select from the list below:

Select ACO

23d. If You selected "Other" to Question 23c. Please specify:

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).
1 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), please answer Q.25, otherwise:
☑ check this box and skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel, sometimes called direct, concierge, or retainer-based practice?
○ Yes ○ No

26. Workers' Compensation

Workers' Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- ○ Not Applicable (Do not complete below)
- ○ I do not practice in Maryland.
- ◉ I do not employ anyone in my practice in Maryland.
- ○ I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in
Question 18 - Primary Practice / Office Location Primary Practice / Office Location

Please complete the following HIT questions for: DuPont Clinic

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?

◉ Yes ○ No

b. To send prescriptions electronically to a pharmacy?

◉ Yes ○ No

If you answered Yes to 1b, what percentage of prescriptions are submitted electronically? 50 %
(Enter whole number)

c. To generate reminders for you about preventive services needed for your patients?

○ Yes ◉ No

d. To access patient notes, medication lists, or problem lists?

◉ Yes ○ No

e. For clinical data and image exchanges with other physicians?

○ Yes ◉ No

f. For clinical data and image exchanges with hospitals and laboratories?

◉ Yes ○ No

g. To communicate about clinical issues with patients by email?

◉ Yes ○ No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

◉ Yes ○ No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

◉ Yes, all electronic ○ Yes, part paper and part electronic ○ No ○ Don't know

2a. If Yes, what is the name and version of the EHR system?

athenaClinicals

Other

2b. If **No,** please indicate your most significant reason for not using electronic medical records.

○ Capital cost outlays ○ Lack of technology standards ○ Retiring soon
○ Overburdened staff ○ Intangible benefits ○ Not my decision
○ Risk of privacy breaches

3. Have you used telemedicine for any purpose in the last 12 months?

○ Yes ◉ No

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 0
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?

☐ Second opinion
☐ Diagnosis
☐ Follow up
☐ Emergency
☐ Chronic disease management
☐ Other (specify)

The following questions are to be answered ONLY if your Practice Setting is one of the following:
(1) Solo; (2) Single-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff

4. Does your practice use high speed Internet?

◉ Yes ○ No

4a. Comcast *Please Specify :*

5. How do you access the Internet?

○ DSL ◉ Cable Modem ○ Fiber to the office ○ Wireless ○ Other ○ Unknown

6. Do you provide Wi-Fi access to your patients in your waiting area?

◉ Yes ○ No ○ Unknown

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

28. The Maryland Responds Medical Reserve Corps (MRC) is a volunteer program that supports Maryland's public health infrastructure and emergency response capabilities. Maryland Responds MRC volunteers are provided with emergency response training opportunities that prepare them to volunteer their skills and expertise during public health emergencies.

If you are interested in learning more about the Maryland Responds MRC and how you can get involved, enter your email address here:

29. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ * d. Pursuant to Health Occupations §14-316, the Board may not renew a license if the criminal history record check information has not been received. By completing this renewal, **you are attesting that you have completed your Criminal History Records Check.** Failure to submit to a criminal history check is a violation of §14-404(a)(42) and may result in disciplinary action.

30. Please provide your electronic signature (type your name) below:

Name: Matthew F Reeves

Today's Date: 8/25/2017

Last four digits of Social Security Number:

31. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started 8/25/2017

Date Application Submitted 8/25/2017

Confirmation Number
Payment Method
Amount Paid
Credit Card Approval:
Credit Card Trans ID