@Print

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

DL -----

	al National Provider Identifier NPI: 1477528966						
Search	Search NPI: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do						
3. EMAIL AD	DRESS: Please enter your most current email address where we may contact you regarding your license.						
A dd Ob.	Also Dublis and Dublish						
You must submit a Your address(es)	nges (Non-Public and Public):  Public and Non-Public address. If either address has changed, please correct here.  In the online renewal application is current as of July 1, 2015. If you requested any changes to your address(es) that are not reflected on this application, hange at this time. These changes will be updated in the main database.						
	ic Address: This address is for Board use only and is where your license will be mailed. However, if no is listed, this address will also be made available to the public.						
Street							
Street (2)							
Street (3)							
City							
State	Foreign" as your state						
ZipCode	-breight as your state						
Country							
	Idress: This address, usually your office, is available to the public and will be posted on the Internet. If you do public address, your non-public address will be posted on the Internet.						
☐ Check if Pu	iblic Address is the same as your Non-Public address (the address above will be automatically entered below.)						
Street	P.O.Box 42288						
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 Country	20015 United States						

CHARACTER AND FITNESS (Question 6)

- 6. The following questions pertain to the period since July 1, 2013. 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.

the Federation of State Medical Boards' Physician Data Center? See instruction

Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

● Yes O No

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- I. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

	<ul> <li>Have you failed to make arrangements to satisfy any state or federal loans that financed your</li> </ul>
	q. Have you failed to make alrangements to satisfy any otation medical education?
	TOUGHTION (Overfice 7)
<ul><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•<li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><l></l></li></ul>	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 two-year period immediately preceding the submission of my application for license renewal.
0	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.
0	c. First Renewal after reinstatement. The CME requirement does not apply to me during this renewal period because this is my first renewal after reinstatement of my medical license.
* Th	e 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
	THE ADDIV
	RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY
Are	e you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central serican, or other Spanish culture or origin, regardless of race.)
	ect 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 subconfinent 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
0	Are you employed by the Federal Government?
	Yes  No
=	I. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical ducation 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 <b>Yes</b> to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of is application.
a.	In an accredited/approved internship or residency program?
(	O Yes ● No
b.	In an accredited fellowship (subspecialty) training program?
	O Yes ● No

11a. Which best describes your current area(s) of concentration:

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Ostoopathic Association (ACA).  Primary Certification Secondary	Primary Concentration Secondary Concentration	and the second	etrics & Gynecology sound	5-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	~	
Primary Certification Secondary Certification Secondary Certification None    2. Please select all states (excluding Maryland) where you hold a medical license.	11b. SPECIALTY BOAR American Board of Medi	D CERTIFI	CATION: List up to titles (ABMS) or the A	wo (2) specialty areas	s only if certified by Association (AOA).	a recognized board of the
12. Please select all states (excluding Maryland) where you hold a medical license.    Alabama					vi '	
Alabama	Secondary Certification	None			~	
Alaska	12. Please select all stat	es (excludir	ng Maryland) where	ou hold a medical lic	cense.	
Arizona	Alabama	☐Florida	☐ Kentucky	Nebraska	Oklahoma	□ Utah
Arkansas	Alaska	Georgia	a 🗆 Louisiana	Nevada	Oregon	Vermont
Arkansas	Arizona	Guam	Maine	☐ New Hampshire	Pennsylvania	☑ Virginia
California	Arkansas	Hawaii	Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
Colorado	California	□ldaho	Michigan	☐ New Mexico	☐ Rhode Island	☐Washington
□ Connecticut □ Indiana □ Mississippi □ North Carolina □ South Dakota □ Wisconsin □ Delaware □ Iowa □ Missouri □ North Dakota □ Tennessee □ Wyoming □ District of Columbia □ Kansas □ Montana □ Ohio □ Texas □ Texas □ Texas □ Montana □ Ohio □ Texas □ Texas □ Montana □ Ohio □ Texas □ Texa	Colorado	□ Illinois	Minnesota	☐ New York	☐ South Carolina	
Delaware	☐ Connecticut	□Indiana	Mississippi	☐ North Carolina		9
District of Columbia	Delaware	□lowa	3.65			
13a. How many weeks per year do you work?  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.  13b. Please indicate 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.  13b. Please indicate 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.  13b. Please 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.  14b. Research includes clinical, laboratory, and analytical research  15b. Deferministration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs; Other:  15c. Use whole numbers. No fractional hours. If none enter 0.  15c. Please related Activities & hours per week  15c. Teaching hours per week  15c. Do you plan to discontinue patient care related activities in the next two years?  15c. Please No						L vvyoming
## 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   Nours per week   b. Research   Nours per week   b. Research   Nours per week   c. Teaching   Nours per week   d. Administration & Other   Nours per week   hours per week   Total Hours   Nours    **PRACTICE INFORMATION (Questions 15-28)**  15. Do you plan to discontinue patient care related activities in the next two years?  **O Yes **O No***  **PRACTICE INFORMATION (Questions 15-28)**  15. Do you plan to discontinue patient care related activities in the next two years?  **O Yes **O No***  **Nourse   Nourse    **Teaching   Nourse	13a. How many weeks p	er year do y	you work? 48			-
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  **Ouse whole numbers.** No fractional hours.** If none enter 0. a. Patient Care Related Activities	13b. Please indicate belonumber of hours in your	ow how the typical work	hours are allocated it week. Definitions of	n your typical work w these categories are	reek . The sum of the listed below.	ese hours should reflect the
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  **O Use whole numbers. No fractional hours. If none enter 0. a. Patient Care Related Activities   8	If you allocate 0 hou Information section (Que	rs per wee stions 15-2	k to a. Patient Care I 6) of this application.	Related Activities you	ı will not be required	to complete the Practice
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   hours per week   b. Research     hours per week   c. Teaching     4 hours per week   d. Administration & Other   20 hours per week   Total Hours     40 hours per week   Total Hours     40 hours per week   Total Hours     14. If you indicated in Question 13 that you are not engaged in 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	and radiologic assessme	nts), mainta	aining patient records	<ol> <li>obtaining and revie</li> </ol>	s, patient-related clir wing test results, ar	nical activities (such as pathologic ranging referrals, consulting with
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 hours per week b. Research c. Teaching d. Administration & Other Total Hours  4 hours per week hours per week hours per week Total Hours  14. If you indicated in Question 13 that you are not engaged in 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						
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 hours per week b. Research c. Teaching d. Administration & Other Total Hours  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					ts and other gradua	te students
a. Patient Care Related Activities hours per week b. Research c. Teaching d. Administration & Other Total Hours  4 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	Administration & Other activities) & managemen	: Administration	ation includes practic	e management (billir	ng, contract negotiat	ions, personnel regulatory
a. Patient Care Related Activities hours per week b. Research c. Teaching d. Administration & Other Total Hours  4 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	Use whole numbers.	No fractiona	I hours. If none enter	0.		
c. Teaching d. Administration & Other Total Hours  4 hours per week hours per week hours per week 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						
d. Administration & Other Total Hours    Au	b. Research		8 hours per v	week		
Total Hours  40 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	AND ALL CONTROL OF THE PARTY OF		4 hours per v	veek		
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		ner				
PRACTICE INFORMATION (Questions 15-26)  15. Do you plan to discontinue patient care related activities in the next two years?  Yes No	Total Hours		40 hours per v	veek		
15. Do you plan to discontinue patient care related activities in the next two years?  O Yes  No	related activities in the ne	estion 13 thext two year	nat you are not engaç rs?	ged in patient care re	lated activities, do y	ou intend to resume patient care
15. Do you plan to discontinue patient care related activities in the next two years?  O Yes  No						
O Yes ● No	PRACTICE INFORMAT	TON (Question	ons 15-26)			
O Yes ● No	15. Do vou plan to disc	continue na	tient care related act	ivities in the payt two	vears?	
16. Please indicate below the number of practice/office locations at which you routingly deliver at the state of the state			Salata dol		, out :	
THE CHARGE DESIGNATION OF DESCRIPTION OF TRANSPORT OF MAINTAIN ASSESSMENT ASS	16 Pleass indicate be	low the ave	phor of prosting last	Josefiers of the		

https://www.mbp.state.md.us/MBP\_MZ\_2015/application.aspx?admin=1&licno=D00698... 10/10/2017

		in Maryland (if none, enter 0)  2  outside of Maryland (if none, enter 0)	
		s outside Maryland, please answer (c) below after you	
	c. Do you routinely trea	t Maryland patients at your practice/office location(s) outside of Maryland?	
		Don't know	
7.	Please indicate below the	e number of hospitals at which you currently have admitting privileges.	
		Maryland (if none, enter 0)	
b.	Number of hospitals out	side of Maryland (if none, enter 0)	
8.	Primary Practice / Offic	e Location Primary Practice / Office Location	
P	lease answer all Primary Pra	ctice questions	
	Organization Name	Planned Parenthood of Metro Wash DC	
	Organization Name2		
).	Street Address	1400 Spring St Suite 450	
	Street2	Enter suite or room number here. (Ex. Suite 101 or Room 101)	
	City	Silver Spring	
	State	Maryland V	
	Zip Code	20910	
<b>g</b> .	Jurisdiction	MONTGOMERY	
	Faralassa Tay ID	If you do not have an EIN enter 00-0000000	
1.	Employer Tax ID		
		What is Employer tax ID?	
	Please select one of the	following related to the NPI used for billing insurers:	
	O I use an Organization	onal NPI for billing. Please Enter >	
	l use my Individual	. Organizational NPI	
	O I do not bill public o	r private insurers.	
	O I can not find my Or	rganizational NPI.	
	Vau indicated in Questic	on 13a, 8 hours of Patient Care Related Activities during a typical work	
	week.		
	this practice/office locat	ient Care Related Activity hours in your typical work week are delivered at ion?	
	If none, enter 0.	Hours	
ζ.	Setting	Free Standing Medical Facility	
	AND ADDRESS AND A	Private-Not for profit	
١.	Private/Public		

### 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

			approform		
			carafem		
(	Organiza	ation Name2			
	Street A	ddroes	1156 15th St NW #700		
. `	Street A	uuless			
. :	Street2		Enter suite or room number (Ex. Suite 101 or Room 101)		
	City		Washington		
	State		District of Columbia		
	Zip Cod		20005		
	Jurisdic		Non-Maryland		
. ,	,	tion	Non-Maryland		
ı.	Employ	er Tax ID	If you do not have an EIN enter 00-0000000		
			What is Employer tax ID?		
	Please	select one of the fo	ollowing related to the NPI used for billing insurers:		
	O I us	se an Organization	nal NPI for billing. Please Enter >		
	<b>⊚</b> I us	se my Individual Ni	PI for billing. Organizational NP	1	
	OIdc	not bill public or p	private insurers.		
	Olca	an not find my Orga	anizational NPI.		
	week. How ma	any of those Patie	n 13a, 8 hours of Patient Care Related Activities during a typical work  nt Care Related Activity hours in your typical work week are delivered at	]	
	week. How mathis pra		nt Care Related Activity hours in your typical work week are delivered at	]	
	week. How ma	any of those Patier	nt Care Related Activity hours in your typical work week are delivered at n?	]	
	week. How mathis pra	any of those Patier ctice/office locatio one, enter 0.	nt Care Related Activity hours in your typical work week are delivered at n?  1 Hours	]	
<b>c</b> .	week. How mathis pra	any of those Patier ctice/office location one, enter 0.	nt Care Related Activity hours in your typical work week are delivered at n?    1	]	
<b>C</b> .	week. How mathis pra	any of those Patier ctice/office location one, enter 0.	nt Care Related Activity hours in your typical work week are delivered at hours    1	]	
C. m. 0-2 ech 2. F	week. How mathis pra If no Setting Private. Practice  21 The Hennology's Please in	any of those Patier ctice/office locatione, enter 0.  /Public e ealth Information Tecection ONLY if you is	nt Care Related Activity hours in your typical work week are delivered at hours    1		
C. m. 0-2 ech 2. F	week. How mathis pra If no Setting Private. Practice  21 The Hennology's Please in rance pro	any of those Patier ctice/office locatione, enter 0.  /Public e  ealth Information Teception ONLY if you indicate if you participagram patients.	Int Care Related Activity hours in your typical work week are delivered at hours.  Free Standing Medical Facility  Private-Not for profit  Other Contractual-Associate Staff (Individual only)  Chnology questions have been moved to a separate section. You are required to complete the have a Primary Practice Location.  ate in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete.		
C. m. 0-2 ect	week. How mathis pra If no Setting Private. Practico	any of those Patier ctice/office locatione, enter 0.  /Public e  ealth Information Tecestion ONLY if you indicate if you participate or patients.	Int Care Related Activity hours in your typical work week are delivered at hours.  Free Standing Medical Facility  Private-Not for profit  Other Contractual-Associate Staff (Individual only)  Chnology questions have been moved to a separate section. You are required to complete the have a Primary Practice Location.  ate in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete in the following private and public insurance programs, and whether you are currently accomplete.	epting	new publ
C. m. 0-2 ech 2. F	week. How mathis pra If no Setting Private. Practico  21 The Hennology's Please in rance pro a. Par	any of those Patier ctice/office locatione, enter 0.  /Public e  ealth Information Teception ONLY if you indicate if you participate and patients.  rticipate in any PRIV.	Int Care Related Activity hours in your typical work week are delivered at hours.  Free Standing Medical Facility  Private-Not for profit  Other Contractual-Associate Staff (Individual only)  Chnology questions have been moved to a separate section. You are required to complete the have a Primary Practice Location.  ate in the following private and public insurance programs, and whether you are currently accomplete insurance plan networks, including PPO, EPO, HMO, etc.	epting of the Yes	new publ O No
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23. Do you offer a sliding fee s  Yes O No O NA	cale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)
23a. Do you participate in a va	lue-based payment program?
23b. If YES, please indicate w	hat 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 below:	s selected from the list above, please indicate which ACO you predominately participate with by select from the list
Select ACO	<b>▽</b>
23d. If You selected "Other" to	Question 23c. Please specify:
24. Please report the typical n	umber of hours per week you personally provide care to patients on a charity basis (do not include bad debt). k.   If none, enter 0
check this box and skip to	It primary care specialist (internal medicine, family practice, general medicine), please answer Q.25, otherwise: Q.26. annual fee for participating on your patient panel, sometimes called direct, concierge, or retainer-based practice?
Workers' Compensation cover complying with the Workers' Compensation coverage with the Workers' Compensati	
OI do not employ anyon	e in my practice in Maryland.
E VE	persons in my Maryland practice and have the following Workers' Compensation coverage. employer you must provide the information requested below.
Insurance Company	
Policy Number Expiration Date	Enter as MM/DD/YYYY
DHMH is interested in learning	g the extent to which physicians are performing sterile compounding at their practice locations.
Compounding is the prepar patient. As defined by the F acts that are performed in a manufacturer directions cor	ation of a medication that is not commercially available in the strength, concentration, or form needed for a specific ederal Drug Quality and Security Act, the term 'compounding' does not include "mixing, reconstituting, or other such ccordance with directions contained in approved labeling provided by the product's manufacturer and other isstent with that labeling". Sterile compounding is the manipulation of a sterile or nonsterile product intended to ict, such as intravenous, epidural, and intraocular medications.
26a. Does your practice of me	edicine involve use of sterile compounded products?
26b. If Yes, is sterile compour	nding being performed at your practice location?
OYes ONo	
HEALTH INFORMATION T	ECHNOLOGY
Please contact the Maryland Hea	alth 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 <a href="http://www.cms.gov/EHRIncentivePrograms/">http://www.cms.gov/EHRIncentivePrograms/</a>

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: Planned P	arenthood of Metro Wash DC
<ol> <li>This question is about the use of computers and other for or treating your patients in your office.</li> </ol>	orms of information technology, such as hand-held computers, in diagnosing
Are you computerized in your office:  a. To obtain information about treatment alternatives	or recommended guidelines?
● Yes O No	
<ul> <li>b. To send prescriptions electronically to a pharmacy</li> <li>Yes O No</li> </ul>	?
If you answered Yes to 1b, what percentage of preso (Enter whole number)	criptions are submitted electronically? 50 %
c. To generate reminders for you about preventive so  Yes O No	ervices needed for your patients?
d. To access patient notes, medication lists, or probl	em lists?
e. For clinical data and image exchanges with other  • Yes O No	physicians?
f. For clinical data and image exchanges with hospit  ○ Yes   No	als and laboratories?
g. To communicate about clinical issues with patient  ○Yes   No	s by email?
h. To obtain information on potential patient drug int  Yes O No	eractions with other drugs, allergies, and/or patient conditions?
Does your primary office/practice location use electronic     Yes, all electronic Yes, part paper and part electronic Yes, part paper and yes, paper	ic MEDICAL RECORDS (not including billing records)? onic O No O Don't know
2a. If Yes, what is the name and version of the EHR NextGen Ambulatory EHR	system?
Other	and the second published
2b. If <b>No</b> , please indicate your most significant reas	on for not using electronic medical records.
	y standards O Retiring soon
Overburdened staff Intangible benefits Risk of privacy breaches	Not my decision
3. Have you used telemedicine for any purpose in the las	it 12 months?

telecommu	nications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of the health care provider at a site other than the site at which the patient is located.
	how many times in the last 12 months have you used telemedicine for any purpose? 0
3b. If you used tele	medicine, what are your common uses of telemedicine technology (mark all that apply)?
Diagnosis	
☐ Follow up	
☐ Emergency	
☐ Chronic diseas	se management
Other (specify)	
	estions are to be answered ONLY if your Practice Setting is one of the following: le-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff
4. Does your prac	tice use high speed Internet?
OYes ONo	
4a. If Yes, selec	ct your internet provider from the list below.    Please Specify:
5. How do you ac	cess the Internet?
ODSL O Cabi	e Modem O Fiber to the office O Wireless O Other O Unknown
6. Do vou provide	Wi-Fi access to your patients in your waiting area?
OYes ONo	
0 100 0 110	
PHYSICIANS E	MERGENCY CONTACT INFORMATION
identified the need respond to a catast	land's emergency preparedness efforts, the Department of Health and Mental Hygiene has for certain contact information for licensed physicians in Maryland who may be needed to rophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article eq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental
* Required Field	
Please provide the	phone number that should be used in the event of an actual emergency.
Daytime *	
Nighttime*	
Indicate by checkin following specific as	g any box that applies whether you have any particular training and experience regarding the gents:  Biological Radiological
	d in being contacted about training opportunities provided by the Board of Physicians, please visit ssional Volunteer Corps website at <a href="https://mdresponds.dhmh.maryland.gov/">https://mdresponds.dhmh.maryland.gov/</a> .
	Thank you for your assistance!
28. CERTIFICA	TION AND AUTHORIZATION OF LICENSE APPLICATION
<b>✓</b>	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, the Healthcare Integrity and Protection 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.
Ø	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. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 9/30/2015.

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

Name

Matthew Reeves

Today's Date

8/24/2015

Last four digits of Social

Security Number:

30. 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

8/24/2015

Date Application Submitted

8/24/2015

Confirmation Number

Payment Method

Amount Paid

Credit Card Approval:

**∄**Print

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

Application for renewal	of: Physicians

2. Th	dividual National Provider Identifier NPI: 1477528966
. EMAI ddress p	IL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email please indicate by checking the checkbox below.
٦	not have an email address
I do I	not have an email address
ou must s	s Changes (Non-Public and Public):  ubmit a Public and Non-Public address. If either address has changed, please correct here.  ss(es) on the online renewal application is current as of July 1, 2013. If you requested any changes to your address(es) that are not reflected on this application  te the change at this time. These changes will be updated in the main database.
a. Non- ublic add	<b>Public Address</b> : This address is for Board use only and is where your license will be mailed. However, if no dress is listed, this address will also be made available to the public.
treet (2)	
treet (3)	
ity	
tate	reign" as your state
ZipCode	
ountry	
ot desig	lic Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do nate a public address, your non-public address will be posted on the Internet.  k if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)
Street	P.O.Box 42288
Street (2)	
Street (3)	
City	Washington
State	District of Columbia
ipCode	If selecting a country other than USA or Canada, please choose "Foreign" as your state
Country	United States

CHARACTER AND FITNESS (Question 6)

- 6. The following questions pertain to the period since July 1, 2011. 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 any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
  - b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- I. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q.	Have you failed to make arrangements to satisfy any state or federal loans that financed you medical education?	ur
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CONTINUING	MEDICAL	EDUCATION	(Question /)

- a. CME met. I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two-year period immediately preceding submission of this application for license renewal. Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.
- 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. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2011 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the orientation.
- C. First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

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

9. Are you employed by the Federal Government?

O 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?

O Yes 

No

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

O Yes 

No

rimary Concentration	Gyneco	ology		~	
econdary Concentration	None			<u> </u>	
1b. SPECIALTY BOARI merican Board of Medic					a recognized board of the
rimary Certification	-	rics & Gynecology		¥	
econdary Certification	None				
2. Please select all state	es (excluding	g Maryland) where y	ou hold a medical lic	ense.	
Alabama	Florida	☐ Kentucky	Nebraska	Oklahoma	Utah
☐Alaska	Georgia	Louisiana	Nevada	Oregon	□Vermont
Arizona	Guam	□Maine	☐ New Hampshire	Pennsylvania	☑ Virginia
Arkansas	Hawaii	Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
California	Idaho	Michigan	☐ New Mexico	☐ Rhode Island	Washington
Colorado	□ Illinois	Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	Mississippi	☐ North Carolina	☐ South Dakota	Wisconsin
☐ Delaware	□ Iowa	□Missouri	☐ North Dakota	Tennessee	□Wyoming
District of Columbia		Montana	Ohio	Texas	
Bb. Please indicate below the properties of hours in your of If you allocate 0 hour formation section (Que	ow how the typical work ars per weel estions 15-26	hours are allocated week. Definitions of k to a. Patient Care 6) of this application	f these categories are Related Activities you	e listed below. u will not be required	d to complete the Practice
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3b. Please indicate beloumber of hours in your allocate 0 hours formation section (Que catient Care Related And Indicated in Care Related And Indicated in Que catient Care Related And Indicated in Que catient Care Related Section (Que catient Care Related Administration & Other Cativities) & management institutions or programs)  Use whole numbers. A Patient Care Related Description of Research Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration & Other Care Related Description (Care Related Description)  Administration (Care Related Description)  Administration (Care Related Description)	ow how the latypical work  ors per weel estions 15-26 ctivities incents), maintatients, talkin cal, laborator eaching of m r: Administration in the of institution cal Activities ther	hours are allocated week. Definitions or k to a. Patient Care (a) of this application lude seeing patients aining patient record g with a patient's fairry, and analytical record and includes practions or programs (he) hours per hours pe	in your typical work we feel these categories are Related Activities you so, writing prescriptions so, obtaining and reviewilly members.  It is a graduate studer the activities graduate studer the activities and departments, he week week week week week week	e listed below.  u will not be required  s, patient-related cli  ewing test results, a  ats and other gradua  ng, contract negotia  alth insurance, hosp	d to complete the Practice  nical activities (such as patholog rranging referrals, consulting with the students.  tions, personnel, regulatory bitals, other health-related

Hours  nat must be completed.
Hours
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zational NPI
00-000000

		Enter suite or room number (Ex. Suite 101 or Room 101)		
	City	Silver Spring		
	State	Maryland		
-	Zip Code	20910		
	Jurisdiction	MONTGOMERY V		
,				•
I	Employer Tax ID	If you do not have an EIN enter 00-0000	000	
		What is Employer tax ID?		
-	Please select one of the fol	llowing related to the NPI used for billing insurers:		
	O I use an Organizationa	I NPI for billing. Please Enter >		
	O I use my Individual NP	I for billing. Organizational NP	PJ	
	l do not bill public or pr	ivate insurers.		
,	You indicated in Question 1	13a, 8 hours of Patient Care Related Activities during a typical work		
١	week.	Care Related Activity hours in your typical work week are delivered at		
1	this practice/office location?	?2		
	If none, enter 0.	Hours	4	
- 8	Setting	Free Standing Medical Facility		
	Setting Private/Public	Free Standing Medical Facility  Private-Not for profit		
1				
21 :hi	Private/Public Practice  1 The Health Information Technology section ONLY if you ha	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the live a Primary Practice Location.		
21 hi	Private/Public Practice  1 The Health Information Technology section ONLY if you ha	Private-Not for profit  Other Contractual-Associate Staff (Individual only)   nology questions have been moved to a seperate section. You are required to complete the		
21shi	Private/Public  Practice  1 The Health Information Technology section ONLY if you har release indicate if you participate ance program patients.	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the live a Primary Practice Location.	epting	new pub
21 chi Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you har release indicate if you participate ance program patients.	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accomplete the rive and public insurance programs.		new pub
21 Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you have the section of the program patients.  a. Participate in any PRIVAT	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accomplete the rive and public insurance programs.	epting	new pub
21 chi Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you had elease indicate if you participate ance program patients.  a. Participate in any PRIVAT	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the tree a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accomplete insurance plan networks, including PPO, EPO, HMO, etc.	O Yes	new pub No
21 Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you had blease indicate if you participate ance program patients.  a. Participate in any PRIVAT  b. Participate in the MARYLOGARE Organization)	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the tree a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accomplete insurance plan networks, including PPO, EPO, HMO, etc.	O Yes O Yes	new put  No  No
21 Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you had blease indicate if you participate ance program patients.  a. Participate in any PRIVAT  b. Participate in the MARYLOGARE Organization)	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently according in the insurance plan networks, including PPO, EPO, HMO, etc.  AND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed	eepting O Yes	new put  No  No
21 Chi Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you have represented ance program patients.  a. Participate in any PRIVATA  b. Participate in the MARYLA Care Organization)  b1. If Yes, are you accept	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accurrently accurrently insurance plan networks, including PPO, EPO, HMO, etc.  AND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed ting new Maryland Medical Assistance patients?	O Yes O Yes	No No No No
21 chi Pura	Private/Public  Practice  1 The Health Information Technology section ONLY if you have represented ance program patients.  a. Participate in any PRIVATA  b. Participate in the MARYLA Care Organization)  b1. If Yes, are you accept	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently according in the insurance plan networks, including PPO, EPO, HMO, etc.  AND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed	O Yes O Yes Yes Yes	new put  No  No
221 Shiring P	Private/Public Practice  1 The Health Information Technology section ONLY if you have the see indicate if you participate ance program patients.  a. Participate in any PRIVAT  b. Participate in the MARYLL Care Organization)  b1. If Yes, are you accept  c. Participate in the MEDICA	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently accurrently accurrently insurance plan networks, including PPO, EPO, HMO, etc.  AND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed ting new Maryland Medical Assistance patients?	O Yes O Yes	No No No No
221 hh	Private/Public Practice  1 The Health Information Technology section ONLY if you have the see indicate if you participate ance program patients.  a. Participate in any PRIVAT  b. Participate in the MARYLL Care Organization)  b1. If Yes, are you accept  c. Participate in the MEDICA	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following program or a Managed in the following program or a Managed in the following program or a Managed in the following program or a Medicare Advantage Plan)?	O Yes O Yes Yes O Yes Yes O Yes	No No No No
21 Chi Pura	Private/Public Practice  1 The Health Information Technology section ONLY if you have the see indicate if you participate ance program patients.  a. Participate in any PRIVAT  b. Participate in the MARYLL Care Organization)  b1. If Yes, are you accept  c. Participate in the MEDICA	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following program or a Managed in the following program or a Managed in the following program or a Managed in the following program or a Medicare Advantage Plan)?	O Yes O Yes	No No No No
221 221 PP	Private/Public Practice  1 The Health Information Technology section ONLY if you have the section on the program patients.  a. Participate in any PRIVAT Care Organization)  b. Participate in the MARYL Care Organization)  c. Participate in the MEDICA c1. If Yes, are you accept	Private-Not for profit  Other Contractual-Associate Staff (Individual only)  nology questions have been moved to a seperate section. You are required to complete the rive a Primary Practice Location.  e in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following private and public insurance programs, and whether you are currently according in the following program or a Managed in the following program or a Managed in the following program or a Managed in the following program or a Medicare Advantage Plan)?	O Yes O Yes	No No No No

25 Do you shares noticets	an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?
O Yes O No	an annual nee for participating on your patient paner (sometime called unext, condenge, or retainer based process):
26. Workers Compen	sation
verify that you are comp	coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you lying with the Workers' Compensation Law for your renewal to be issued.
I hereby certify:  Not Applicable (Do	net complete holew)
O I do not practice in	
	rone in my practice in Maryland.
	re persons in my Maryland practice and have the following Workers Compensation coverage.
	nd employer you must provide the information requested below.
Insurance Company	
Policy Number	
Expiration Date	Enter as MM/DD/YYYY Enter as MM/DD/YYYY
HEALTH INFORMATIO	N TECHNOLOGY
	Health Care Commission at 410-764-3330 for questions relating to this section.
Electronic Healt	h Record Incentive
Medicare or Med which program you \$63,750 over six	1, physicians that adopt an electronic health record are eligible to receive an incentive either under caid. To receive this incentive, a physician must meet certain criteria, which varies depending on our choose. The Medicare incentive is up to \$44,000 over five years and the Medicaid incentive is up to years. Physicians are encouraged to learn more about these incentive opportunities by visiting the care and Medicaid Services website <a href="http://www.cms.gov/EHRIncentivePrograms/">http://www.cms.gov/EHRIncentivePrograms/</a>
patients at your primary office	e of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your e/practice location, which you listed in tice / Office Location Primary Practice / Office Location
☐ Please check this have a primary office	box if you DO NOT have a primary office location as indicated in Question 18. (If you do no location you will not be required to complete the Health Information Technology questions
This question is about or treating your patients i	the use of computers and other forms of information technology, such as hand-held computers, in diagnosing n your office.
Are you computerized in a. To obtain informa  • Yes O No	your office:
0 100 0 110	ation about treatment alternatives or recommended guidelines?
b. To send prescrip	
b. To send prescrip  Yes O No	ation about treatment alternatives or recommended guidelines?  tions electronically to a pharmacy?
●Yes ○No	tions electronically to a pharmacy? s to 1b, what percentage of prescriptions are submitted electronically? 30 %
Yes O No If you answered Ye (Enter Whole number)	tions electronically to a pharmacy? s to 1b, what percentage of prescriptions are submitted electronically? 30 %
● Yes ○ No If you answered Ye (Enter Whole numb c. To generate rem ○ Yes ● No	tions electronically to a pharmacy? s to 1b, what percentage of prescriptions are submitted electronically? 30 % er)
● Yes ○ No If you answered Ye (Enter Whole numb c. To generate rem ○ Yes ● No	tions electronically to a pharmacy?  s to 1b, what percentage of prescriptions are submitted electronically? 30 %  ser)  inders for you about preventive services needed for your patients?
● Yes ○ No If you answered Ye (Enter Whole numb c. To generate rem ○ Yes ● No d. To access patier ● Yes ○ No	tions electronically to a pharmacy?  s to 1b, what percentage of prescriptions are submitted electronically? 30 %  er)  inders for you about preventive services needed for your patients?

○Yes  ● No
f. For clinical data and image exchanges with hospitals and laboratories?  O Yes  No
g. To communicate about clinical issues with patients by email?  O Yes  No
h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?    Yes O No
2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?  O Yes, all electronic  Yes, part paper and part electronic  O No O Don't know
2a. If Yes, what is the name and version of the EHR system?  NextGen Ambulatory EHR   ✓
Other
2b. If <b>No</b> , 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?
O 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?   [O (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?
O Yes O No
4a. If Yes, select your internet provider from the list below.
5. How do you access the Internet?
ODSL O Cable Modem O Fiber to the office O Wireless O Other O Unknown
6. Do you provide Wi-Fi access to your patients in your waiting area?  OYes ONo OUnknown
프리아 그리고 있는 것이 없는 것이 없는 그는 그 사람들은 사람들은 사람들이 되었다.

PHYSICIANS EMERGENCY CONTACT INFORMATION

identified the need respond to a catast	land's emergency preparedness efforts, the Department of Health and Mental Hygiene has for certain contact information for licensed physicians in Maryland who may be needed to crophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental
* Required Field	
	phone number that should be used in the event of an actual emergency.
Daytime *	
Nighttime*	
Indicate by checkin following specific as	
Chemical	Biological Radiological
	d in being contacted about training opportunities provided by the Board of Physicians, please visit ssional Volunteer Corps website at <a href="https://mdresponds.dhmh.maryland.gov/">https://mdresponds.dhmh.maryland.gov/</a> .
	Thank you for your assistance!
28. CERTIFICAT	TION 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.
lacksquare	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, the Healthcare Integrity and Protection 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.
abla	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. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2013.
29. Please p	rovide your electronic signature (type your name) below:
Name	Matthew Reeves
Today's Date	9/3/2013
Last four digit	
Security Num	bber:
	Payment Option here to complete your application.  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:
	THE CONTROL OF THE C

APPLICATION COMPLETION INFORMATION:
Date Application Started 9/3/2013
Date Application Submitted 9/3/2013

Confirmation Number

https://www.mbp.state.md.us/MBP\_MZ\_2013/application.aspx?admin=1&licno=D00698... 10/10/2017

Payment Method Amount Paid Credit Card Approval No.

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

Application for renewal of: $\Gamma$	Physicians
--------------------------------------	------------

This is the	National Provider Identifier NPI: 1477528966
NPI in	formation
EMAIL ADDF dress please ind	RESS: This is your email address on file. If it has changed, please edit below. If you do not have an email icate by checking the checkbox below.
I do not have	ar
ou must submit a	es (Non-Public and Public): Public and Non-Public address. If either address has changed, please correct here. If the online renewal application is current as of July 1, 2011. If you requested any changes to your address(es) that are not reflected please make the change at this time. These changes will be updated in the main database.
a. Non-Public ublic address is <sup>li</sup> treet	Address: This address is for Board use only and is where your license will be mailed. However, if no sted this address is for Board use only and is where your license will be mailed.
treet (2)	
treet (2)	
ity	
tate	Foreign" as your state
pCode	
ountry	
b. Public Add	ress: This address, usually your office, is available to the public and will be posted on the Internet. If you do ublic address, your non-public address will be posted on the Internet.
Check if Publ	ic Address is the same as your Non-Public address (the address above will be automatically entered below.)
treet	P.O.Box 42288
Street (2)	
Street (3)	
City	Washington
	District of Columbia  If selecting a country other than USA or Canada, please choose "Foreign" as your state
State	
	120015
State	
ZipCode Country	the Maryland Board of Physicians permission to report your date of birth to  Yes O No

- \* All questions must be answered Yes or No.
  - a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
  - b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- I. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education? CONTINUING MEDICAL EDUCATION (Question 7) a. CME met. I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal. 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. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2009 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the O c. First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland. PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17) Ethnicity and Race: (Select all that apply) Hispanic or Latino American Indian or Alaska native 3lack or African American Native Hawaiian or other Pacific Islander 9. Are you employed by the Federal Government? 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. 15-26) If you answer Yes to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of a. In an accredited/approved internship or residency program? b. In an accredited fellowship (subspecialty) training program?

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification

**Primary Concentration** 

Secondary Concentration

orientation.

8a. Gender

Asian

White Other

O Yes 

No

this application.

O Yes 

No

O Yes 

No

Obstetrics & Gynecology

11. Which best describes your current area(s) of concentration:

Gynecology

Ultrasound

Secondary Certification

V

None	V
	work2 [48]
a. How many weeks per year do you	Work: 40
mber of hours in your typical work w	urs in your typical work week are allocated. The sum of these hours should reflect the eek. Definitions of these categories are listed below.
ormation section (Questions 15-26)	o a. Patient Care Related Activities you will not be required to complete the Practice of this application.
ntient Care Related Activities included radiologic assessments), maintain ner providers about patients, talking	de seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic ing patient records, obtaining and reviewing test results, arranging referrals, consulting with with a patient's family members.
esearch includes clinical, laboratory,	
eaching includes teaching of medica	al undergraduate & graduate students and other graduate students.
	on includes practice management (billing, contract negotiations, personnel, regulatory is or programs (health departments, health insurance, hospitals, other health-related
Use whole numbers. No fractional	hours. If none enter 0.
. Patient Care Related Activities	hours per week
. Research	20 hours per week
. Teaching	4 hours per week
. Administration & Other	20 hours per week
otal Hours	48 hours per week
4. If you indicated in Question 13 the elated activities in the next 2 years?  Yes  No	at you are not engaged in patient care related activities, do you intend to resume patient care
elated activities in the next 2 years?	
elated activities in the next 2 years?  Yes No  PRACTICE INFORMATION (Qu	uestions 15-26)
elated activities in the next 2 years?  Yes No  PRACTICE INFORMATION (Qu	uestions 15-26)
elated activities in the next 2 years?  Yes No  PRACTICE INFORMATION (Qu	
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Street2	Enter suite or room number here. (Ex. Suite 101 or Room	그 101)
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City State	District of Columbia	
Zip Code	20036	
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Please select one of the	following related to the NPI used for billing insurers:	
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		ctice/office location? ne, enter 0.					
	Hina		Free Standing Medical Facility				
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0. In	form	ation Technology (F	Primary Practice / Office Location)				
Plea	se ans	wer all Primary Practice I	Information Technology questions				
his q agno	uestio	or treating your patier	f computers and other forms of information technology, such as hand-held compute nts at your primary office/practice location, which you listed in question 18.	ers, in			
● ′es	O No	A. To obtain informa	ation about treatment alternatives or recommended guidelines?				
O ′es	No     No	B. To send prescript	tions electronically to a pharmacy?				
		If you answered Yes submitted electronic	s to 20B, what percentage of prescriptions are cally? Use whole numbers.				
O Yes	● No	C. To generate remi	inders for you about preventive services needed for your patients?				
O Yes	● No	D. To access patien	nt notes, medication lists, or problem lists?				
O Yes	No	E. For clinical data a	and image exchanges WITH OTHER PHYSICIANS?				
O Yes	No	F. For clinical data	and image exchanges WITH HOSPITALS AND LABORATORIES?				
O Yes	No	G. To communicate	e about clinical issues with patients by email?				
Yes	O No	H. To obtain inform	nation on potential patient drug interactions with other drugs, allergies, and/or patie	nt co	nditions?		
21. [	Does	your primary office/pra	ractice location use electronic MEDICAL RECORDS (not including billing records)?	,			
0	Yes,	all electronic OYes,	, part paper and part electronic				
	21	a. If <b>No</b> , please indica	ate your most significant reason for not using electronic medical records.				
		Capital cost outlays					
		Overburdened staff					
	(	Physician resistanc	e to adoption O Intangible benefits				
		indicate if you participate program patients.	e in the following private and public insurance programs, and whether you are currently acce	pting	new public		
	a. P	articipate in any PRIVAT	TE insurance plan networks, including PPO, EPO, HMO, etc.		O No		
		Participate in the MARYL Care Organization)	AND WEDICAL AGGIC PAROL PROGRAM (III CHIEF THE TELEPHONE)		O No		
	b	1. If <b>Yes</b> , are you accep	sting now Manyland Medical Assistance nationts?	<ul><li>Yes</li></ul>	O No		

c. Participate in the MED	DICARE (in either the traditional program or a Medicare Advantage Plan)?	O Yes No			
c1. If <b>Yes</b> , are you ac	cepting 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)					
24. Please report the typical nu 0 hours per week	mber of hours per week you personally provide care to patients on a charity basis	s (do not include bad debt).			
	It primary care specialist (internal medicine, family practice, general medicine), an				
25. Do you charge patients an O Yes   No	annual fee for participating on your patient panel (sometime called direct, concier	ge, or retainer-based practice)?			
verify that you are complying the verify that you are complying the very continuous and the very continuous and the very continuous and very conti	verage: If you employ one or more persons, the Md. Code Ann. Health Cong with the Workers' Compensation Law for your renewal to be issued.  It complete below)  Inyland.  It is in my practice in Maryland.  It persons in my Maryland practice and have the following Workers Compensation requested below.  Enter as MM/DD/YYYY Enter as MM/DD/YYYY				
7. As part of Maryland's eme entified the need for certain	rgency preparedness efforts, the Department of Health and Mental Hygic contact information for licensed physicians in Maryland who may be need lith emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health Curth the powers of the Governor and Secretary of the Department of Health	General Article			
Required Field					
Please provide the phone null Daytime * Sighttime*	nber that should be used in the event of an actual emergency.				
	that applies whether you have any particular training and experience reg	garding the			
f you are interested in being the Maryland Professional Vo	contacted about training opportunities provided by the Board of Physicia olunteer Corps website at <a href="https://mdresponds.dhmh.maryland.gov/">https://mdresponds.dhmh.maryland.gov/</a> .	ins, please visit			

Thank you for your assistance!

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 <a href="http://www.cms.gov/EHRIncentivePrograms/">http://www.cms.gov/EHRIncentivePrograms/</a>

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

Name

Matthew F. Reeves

Today's Date

9/9/2011

Last four digits of Social Security Number:

30. 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 COMPLETIC Date Application Started Date Application Submitted Confirmation Number Payment Method Amount Paid Credit Card Approval No.	9/9/2011 9/9/2011			
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