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://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

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

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, 2015. 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 **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street
Street (2)
Street (3)
City
State
ZipCode
Country

oreign" as your state

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	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	20015
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

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.

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?

l. 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?

q. 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 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.

○ **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.**

○ **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.

** 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

9. Are you employed by the Federal Government?

○ 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.

❶ 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

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

Primary Concentration: Obstetrics & Gynecology
Secondary Concentration: Ultrasound

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 Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ 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	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

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	8	hours per week
c. Teaching	4	hours per week
d. Administration & Other	20	hours per 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

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) 2

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

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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) 1

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

Please answer all Primary Practice questions

a. Organization Name: Planned Parenthood of Metro Wash DC

Organization Name2:

b. Street Address: 1400 Spring St Suite 450

c. Street2:

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

d. City: Silver Spring

e. State: Maryland

f. Zip Code: 20910

g. Jurisdiction: MONTGOMERY

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h. Employer Tax ID

If you do not have an EIN enter 00-0000000

What is Employer tax ID?

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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.

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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? 7 Hours
If none, enter 0.

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k. Setting: Free Standing Medical Facility

l. Private/Public: Private-Not for profit

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

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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

carafem

Organization Name2

b. Street Address: 1156 15th St NW #700

c. Street2

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

d. City: Washington

e. State: District of Columbia

f. Zip Code: 20005

g. Jurisdiction: Non-Maryland

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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?
If none, enter 0.

1 Hours

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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

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23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

◉ Yes ○ No ○ NA

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:

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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).

0 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

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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

DHMH is interested in learning the extent to which physicians are performing sterile compounding at their practice locations.

Compounding is the preparation of a medication that is not commercially available in the strength, concentration, or form needed for a specific patient. As defined by the Federal Drug Quality and Security Act, the term 'compounding' does not include "mixing, reconstituting, or other such acts that are performed in accordance with directions contained in approved labeling provided by the product's manufacturer and other manufacturer directions consistent with that labeling". Sterile compounding is the manipulation of a sterile or nonsterile product intended to produce a sterile final product, such as intravenous, epidural, and intraocular medications.

26a. Does your practice of medicine involve use of sterile compounded products?

○ Yes ◉ No

26b. If Yes, is sterile compounding being performed at your practice location?

○ Yes ○ No

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 http://www.cms.gov/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: Planned Parenthood of Metro Wash DC

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?
NextGen Ambulatory EHR

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. [If Yes, select your internet provider from the list below.] *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 and Mental Hygiene 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 and Mental Hygiene.

* 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

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. 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, 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.

☑ 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**

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

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

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

☐ I do not have an email address

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, 2013 . 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.

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

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

4b. **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	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	20015
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

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?

l. 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?

q. 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 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?

○ 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

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

Primary Concentration: Gynecology
Secondary Concentration: None

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 Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ 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	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

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	4	hours per week
c. Teaching	4	hours per week
d. Administration & Other	24	hours per 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

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) 1

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

Please answer all Primary Practice questions

a. Organization Name: Planned Parenthood of Metro Wash DC

b. Street Address: 1108 16th Street NW

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.

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: Free Standing Medical Facility

l. Private/Public: Private-Not for profit

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

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: Planned Parenthood of Metro Wash DC

b. Street Address: 1400 Spring Street

c. Street2

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

d. City: Silver Spring

e. State: Maryland

f. Zip Code: 20910

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.

---

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? 2 Hours
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 seperate 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 ○ NA

---

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).

0 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 (sometime 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 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 http://www.cms.gov/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 check this box if you DO NOT have a primary office location as indicated in Question 18. (If you do not have a primary office location you will not be required to complete the Health Information Technology questions.)***

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? 30 %
(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?

NextGen Ambulatory EHR

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. If Yes, select your internet provider from the list below. *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 and Mental Hygiene 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 and Mental Hygiene.

* 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

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. 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, 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.

☑ 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 provide your electronic signature (type your name) below:

Name	Matthew Reeves
Today's Date	9/3/2013
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	9/3/2013
Date Application Submitted	9/3/2013
Confirmation Number	

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: **Physicians**

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

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

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

☐ I do not have ar

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, 2011 . 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 **where your license will be mailed**. However, if no public address is listed, this address

Street
Street (2)
Street (3)
City
State
ZipCode
Country

Foreign" as your state

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	P.O.Box 42288
Street (2)	
Street (3)	
City	Washington
State	District of Columbia
ZipCode	20015
Country	United States

If selecting a country other than USA or Canada, please choose "Foreign" as your state

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2009. 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?

l. 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?

q. 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 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

Ethnicity and Race: (Select all that apply)

Hispanic or Latino
American Indian or Alaska native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other

---

9. Are you employed by the Federal Government?

○ 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

---

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

Primary Concentration: Gynecology

Secondary Concentration: Ultrasound

---

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: Obstetrics & Gynecology

Secondary Certification

None

13a. How many weeks per year do you work? 48

13b. Please indicate below how the hours in your typical work week are allocated. 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 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	4	hours per week
b. Research	20	hours per week
c. Teaching	4	hours per week
d. Administration & Other	20	hours per week
Total Hours	48	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 2 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) 0

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

Please answer all Primary Practice questions

a. Organization Name Planned Parenthood of Metro Wash DC

b. Street Address 1108 16th Street NW

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 >**
- ○ **I use my Individual NPI for billing.**
- ◉ **I do not bill public or private insurers.**

Organizational NPI

j. You indicated in Question 13a, 4 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?

If none, enter 0.

3 Hours

k. Setting: Free Standing Medical Facility

l. Private/Public: Private-Not for profit

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

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: Planned Parenthood of Metro Wash DC

b. Street Address: 1400 Spring Street #450

c. Street2

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

d. City: Silver Spring

e. State: Maryland

f. Zip Code: 20910

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 >**
- ○ **I use my Individual NPI for billing.**
- ◉ **I do not bill public or private insurers.**

Organizational NPI

j. You indicated in Question 13a, 4 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

1 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. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

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.

(●) Yes ( ) No A. To obtain information about treatment alternatives or recommended guidelines?

( ) Yes (●) No B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. ____ %

( ) Yes (●) No 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?

21. 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

21a. If **No,** please indicate your most significant reason for not using electronic medical records.

( ) Capital cost outlays ( ) Risk of privacy breaches ( ) Retiring soon
( ) Overburdened staff ( ) Lack of technology standards (●) Not my decision
( ) Physician resistance to adoption ( ) Intangible benefits

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 ○ NA

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).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime 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 Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene 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 and Mental Hygiene.

* 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

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

28. 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, 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.

☑ 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 12/1/2011.

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 http://www.cms.gov/EHRIncentivePrograms/

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 COMPLETION INFORMATION:

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