261015

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JUN 23 2014
Board of Registration in Medicine

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

FULL LICENSE APPLICATION

REDACTED COPY

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License [x] Initial Full License [ ] Administrative License [ ] Volunteer License

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

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

Woodhams	Elisabeth	Joan	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

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

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

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

Social Security Number: _____ Date of Birth: _____
Month Day Year

NPI (National Provider Identifier) Number: 1235304403

Place of Birth: _____ _____
City State/Province/Territory Country if not USA

*Mailing Address: _____ _____ Telephone:
Number and Street

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

Home Address: _____ _____ Telephone:
Number and Street

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

Business Address: _____ Telephone: _____
Number and Street

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

E-mail Address: _____ Fax number: _____

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

*** The Board will use your Mailing Address for all correspondence**

Revised: 01.22.2014

Pre-medical School **From** **To**

Name: Trinity College Degree: BS Year: 1999 Year: 2003

Street: 300 Summit Street City: Hartford State: CT

Name: Degree: Year: Year:

Street: City: State:

Medical School

Name : University of Arizona College of Medicine Degree: MD

Street: 1501 N Campbell Ave City: Tucson State: AZ

Name: Degree:

Street: City: State:

Medical School Graduation Date: 5 / 2007
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

From **To**

Facility: Boston University Medical Center PGY Year: 1-4 6/2007 7/ 2011

Specialty: OB/GYN City: Boston State: MA

Facility University of Chicago PGY Year: 5&6 6/2011 7/2013

Specialty:: Family Planning (OB/GYN) City: Chicago State: IL

Facility: PGY Year: / /

Specialty: City: State:

Facility: PGY Year: / /

Specialty: City: State:

Facility: PGY Year: / /

Specialty: City: State:

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination). If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	1	[x] P [ ] F
USMLE Step II	1	[x] P [ ] F
USMLE Step III	1	[x] P [ ] F
NBME Part I		[ ] P [ ] F
NBME Part II		[ ] P [ ] F
NBME Part III		[ ] P [ ] F
FLEX Component 1		[ ] P [ ] F
FLEX Component 2		[ ] P [ ] F
FLEX Pre-1985		[ ] P [ ] F
NBOME Part I		[ ] P [ ] F
NBOME Part II		[ ] P [ ] F
NBOME Part III		[ ] P [ ] F
COMLEX Level 1		[ ] P [ ] F
COMLEX Level 2		[ ] P [ ] F
COMLEX Level 3		[ ] P [ ] F
COMVEX		[ ] P [ ] F
LMCC – Single		[ ] P [ ] F
LMCC – Part I		[ ] P [ ] F
LMCC – Part II		[ ] P [ ] F
State Board Exam	(State of examination and year)	[ ] P [ ] F

Hospital Affiliations and Employment

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

		From	To
Facility: Thomas Jefferson Medical College	Position: Assistant Professor	8 /2013	current
Street: 834 Chestnut Street	City: Philadelphia	State: PA	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: IL PA

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes X No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes X No

3. List Board Certification(s):

4. List your practice specialt(ies) OB/GYN

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page 4) ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: Employment at Boston Medical Center

7. Name of Facility: Boston University Medical Center

   Address: 1 Boston Medical Center Place

   City: Boston

8. Anticipated starting date in Massachusetts: November / 1 / 2014

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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

Signature of Applicant

6 / 6 / 2014
Month Day Year

3.3.14

Hospital Affiliations and Employment

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

		From	**To**
Facility: Thomas Jefferson Medical College	Position: Assistant Professor	8 /2013	current
Street: 834 Chestnut Street	City: Philadelphia	State: PA	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: IL

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes X No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes X No

3. List Board Certification(s):

4. List your practice specialt(ies) OB/GYN

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page 4) ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: Employment at Boston Medical Center

7. Name of Facility: Boston University Medical Center

   Address: 1 Boston Medical Center Place

   City: Boston

8. Anticipated starting date in Massachusetts: November / 1 / 2014

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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

Signature of Applicant

6 / 6 / 2014
Month Day Year

FULL LICENSE APPLICATION SUPPLEMENT

PRINT NAME: Elisabeth Williams DATE: 6/18/14

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5 - 10.

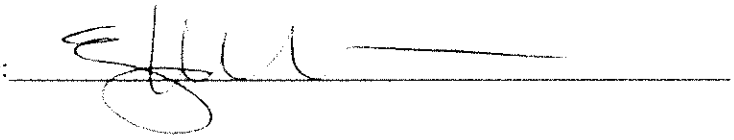
QUESTIONS	YES	NO
1. While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3. If you are a U.S. or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: ELISABETH WILLIAMS DATE: 6/10/14

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any State) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any State) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any State)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

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

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

Applicant's Signature:  Date: 6/6/14

01.28.2014

COMMONWEALTH OF MASSACHUSETTS, BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 – (617) 654-9810 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please Note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

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

Applicant's Signature: E J Woodhams Date of Birth

Print or Type Name: WOODHAMS (Last name) ELISABETH (First Name) J (Middle Initial) Social Security No:

Other Name(s) _____ (Please type or print name(s))

Name of Medical School: UNIVERSITY OF ARIZONA COLLEGE of Medicine

Address: 1501 N. CAMPBELL City: TUCSON State or Province: AZ 85724

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☐ Yes ☒ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Continued on page 2

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that

WOODHAMS (Last name) ELISABETH (First name) J. (Middle initial)

(type or print the applicant's name):

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

ATTENDANCE DATES:

FROM	TO	FROM	TO
07/28/03	05/28/04	07/03/06	03/23/07
07/26/04	05/06/05	/ /	/ /
07/05/05	06/23/06	/ /	/ /

The applicant attended 184 total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year

check one ☐ was awarded a degree in _____ on (month/day/year) ____/____/____

☑ will be awarded on 05/12/07 **(Form B must also be completed and returned with this Form A)**

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Nancy Huff

Print Name: NANCY HUFF

Title: Assistant Registrar

Date: 03/28/07 Telephone: (520) 626-2526

This form will not be accepted unless it is stamped with the institutional seal or notarized.

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

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: _____ Date: 4 / 15 / 14

Print or type name: ELISABETH WOODHAMS

License number 036127467 Status of license: ☑ Active ☐ Inactive ☐ Other _____

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: _____
2. Date of graduation: ____/____/____ License number: _____ Date of issue: ____/____/____
3. Basis for licensure: _____
   Name(s) of medical licensing examinations(s)
4. Expiration date of license: ____/____/____
5. Status of license (*check one*): ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

Signed: _____

BOARD SEAL

Print Name: _____

Title: _____

State Board: _____ Date: ____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

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STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: _____ Date: 4 / 15 / 14

Print or type name: ELISABETH WOODHAMS

License number: MO 449067 Status of license: ☑ Active ☐ Inactive ☐ Other _____

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: _____
2. Date of graduation: ____/____/____ License number: _____ Date of issue: ____/____/____
3. Basis for licensure:

_____
Name(s) of medical licensing examinations(s).

4. Expiration date of license: ____/____/____
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

_____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

Signed: _____

BOARD SEAL

Print Name: _____

Title: _____

State Board: _____ Date: ____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 4/15/14

Print or Type Name: ELISABETH WOODHAMS

Name of Institution: BOSTON UNIVERSITY MEDICAL CENTER

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Boston Medical Center

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

Enrollment and Participation: Our records indicate that Elisabeth Woodhams participated in the following program:
(Print applicant's name)

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	PGY1	OB/GYN	07/01/07	06/30/08	Yes	ACGME
Residency	PGY2	OB/GYN	07/01/08	06/30/09	Yes	ACGME
Residency	PGY3	OB/GYN	07/01/09	06/30/10	Yes	ACGME
Residency	PGY4	OB/GYN	07/01/10	06/30/11	Yes	ACGME

(Continued on page 2)

APPLICANT'S NAME: Elisabeth Woodhams

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Program Director's Signature: [signature]

Print Name: Michelle Sia, DO

Academic Title: Assistant Professor

Telephone: (617) 414-5116 Today's Date: 04/25/2014

E-mail address: Michelle.Sia@BMC.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 6-24-14
INITIALS: KY

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 4/15/14

Print or Type Name: ELISABETH WOODHAMS

Name of Institution: University of Chicago

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of Chicago

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

Enrollment and Participation: Our records indicate that Elisabeth Woodhams M.D (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Fellowship	5	Family Planning	7/1/2012	6/30/2013	YES	NOT ACCREDITED
Fellowship	6	Family Planning	7/1/2013	6/30/2014	YES	Not accredited

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(Continued on page 2)

APPLICANT'S NAME: ELISABETH WOODHAMS

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☐ ACGME ☐Other: Non Accredited

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____

Print Name: Melissa Gilliam, MD

Academic Title: Program Director

Telephone: (773) 834-0840 Today's Date: 4/24/2014

E-mail address: mgilliam@luriechildrens.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified

DATE: 6-24-14

INITIALS: KV

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 4/15/14

Print or Type Name: ELISABETH WOODHAMS

Name of Institution: University of Chicago

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of Chicago

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

Enrollment and Participation: Our records indicate that Elisabeth Woodhams, M.D (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Fellowship	5&6	Family Planning	7/1/2011	6/30/2013	YES	NOT ACCREDITED

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APR 29 2014
Board of Registration in Medicine

(Continued on page 2)

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Elisabeth J Woodhams, M.D. **License No.:** 261015

Current Status: Active **License Expiration Date:** 9/21/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
840 Harrison Ave
YACC 4th flr
Boston
Massachusetts - 02118
United States of America
(617) 414-3821

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
Pennsylvania

9) **States where you were previously licensed**
Illinois

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Boston Medical Center	Boston MA

Physician Name: Elisabeth J Woodhams, M.D. **License No.:** 261015

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	06/30/2015	06/30/2016	Claims made with tail coverage

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse
Have you completed training to recognize and report suspected child abuse or neglect?

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Elisabeth J Woodhams, M.D. **License No.:** 261015

Current Status: Active **License Expiration Date:** 9/21/2017

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
850 Harrison Ave
YACC 5th flr
Boston
Massachusetts - 02118
United States of America
(617) 414-3821

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

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

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

Elisabeth J. Woodhams MD

EDUCATION

Trinity College
Hartford, CT
B.S. Honors in Neuroscience — **May 2003**

University of Arizona College of Medicine
Tucson, AZ
Doctor of Medicine — **July 2003-May 2007**

University of Chicago
Chicago, IL
Masters of Science for Clinical Professionals — **June 2011 – present**

TRAINING

Boston University Medical Center, Boston MA
Administrative Chief Resident — **March 2010 – June 2011**
Residency Training Program — **July 01 2007 – June 30 2011**

University of Chicago, Chicago IL
Fellow, Family Planning — **July 1 2011 – June 2013**

Physicians for Reproductive Health and Choice — **August 2012 – March 2013**
Fellow, Leadership Training Academy

LICENSURE

Licensed Physician and Surgeon, State of Pennsylvania (License No. MD449067)
Licensed Physician and Surgeon, State of Illinois (License No. 036.127467)
Licensed, Controlled Substance IIN, II, III, IV, V, IIIN (License No. 336.088745)
USMLE Step 1, Steps 2CS and CK, Step 3 passed
Active Candidate, ABOG Written Exam passed

FACULTY APPOINTMENTS — **August 2013 – present**

Assistant Professor
Thomas Jefferson University Hospital, Philadelphia PA
Director, Family Planning
Medical Director, Title X Clinic
Department of Obstetrics and Gynecology

HONORS

Outstanding Investigator in Training, *Society of Family Planning* — **October 2013**
Best Overall Resident - Medical Student Teaching Award, *Boston University School of Medicine* — **June 2010, June 2011**
Medical Student Teaching Award, *Boston University School of Medicine* — **June 2008, June 2009, June 2010, June 2011**
Gold Humanism Award, *Boston University School of Medicine* — **May 2009**
Alvin T. Kirmse, M.D. Award for Excellent in Obstetrics and Gynecology, *University of Arizona College of Medicine* — **May 2007**
The Neuroscience Prize, *Trinity College* — **May 2003**
Long Walk Scholars Award, *Trinity College* — **May 2003**
Faculty Honors, *Trinity College* — **May 2000, May 2001, May 2002, May 2003**

RESEARCH

Fellowship in Family Planning, University of Chicago
Understanding African American adolescent males' perception of responsibility in pregnancy prevention: a mixed methods study

Society of Family Planning funded grant, $70,000 (0% salary support)

Reproductive health correlates of unwanted first sexual experience in young men

Society of Family Planning funded grant, $30,000 (0% salary support)

Department of Anthropology, Trinity College

Research Assistant **May – July 2004**

Examined impact of road construction on disease transmission in small villages in Ecuador as part of a five-year, $2 million NIH sponsored grant. Duties included extensive literature searches, project organization, and abstract and short paper writing.

EXTRAMURAL SPONSORSHIP

Title X Family Planning and HIV Services Integration **August 2013 – present**

Integrating Routine HIV-Testing and Linage to HIV Care and Treatment in Title X Family Planning Service Sites and Enhanced, Bi-Directional Linkage Services between Title X Family Planning Service Sites and Ryan White-Funded HIV Medical Service Sites (Parts A and B)

$153,901 total direct

PI: William Schlaff, MD

Role: Co- Principal Investigator; Program Director; 15% salary support

POSTERS

Rates of Intrauterine Device Discontinuation After Abortion vs. Interval Placement **September 2010**

Woodhams E., Borgatta L. Poster presentation; Association of Reproductive Health Professionals, Atlanta, GA

Tuboovarian Abscess after Hysteroscopy in a Patient with Preexisting Endometriomas **November 2008**

Woodhams E., Irisari. L Poster presentation; Global Congress of Minimally Invasive Gynecology, Las Vegas, NV

Behavior Therapy for Medication Nonresponders with Obsessive Compulsive Disorder **November 2002**

Tobin, D., Woodhams E. Poster presentation; Association for Advancement of Behavioral Therapy, Reno NV

PUBLICATIONS

Woodhams, E, Gilliam M. (2012). Barrier Methods. Contraception for Adolescent and Young Adult Women. Gilliam M, Whitaker AK. Springer Publishing. NY. edition. In publication.

Woodhams E, Gilliam M. Contraception. Annals of Internal Medicine. 2012 Oct;157(7):ITC4-1.

REFEREED PRESENTATIONS

Woodhams EJ, Casey-Gay F, Mistretta S, Martins S, Gilliam MG (2013). Understanding African American adolescent males' responsibility for pregnancy prevention: a focus group study. 2013 North American Forum on Family Planning. Seattle, WA.

Woodhams E, Holmquist S. (2013). "Systems Based Practice – the reproductive health clinic as a teaching tool." 2013 Association of Professors of Obstetrics and Gynecology Martin L Stone, MD Faculty Development Seminar. Maui, HI.

LECTURES AND PRESENTATIONS

"Election 101: Health Care Reform, Clinical Practice Legislation, and Why you still need to vote (even in Illinois)," *Grand Rounds, Dept OB/GYN* University of Chicago **October 2012**

"Disparities in Teen Reproductive Health," Pritzker School of Medicine, University of Chicago **July 2012**

"Abortion: Jeopardy," & "Pain Management & Abortion," *TEACH II, Dept OB/GYN*, Stritch School of Medicine Loyola University **March 2012 2013**

"Contraception Basics: Jeopardy," *TEACH I, Dept OB/GYN*, Stritch School of Medicine, Loyola University **October 2011 2012**

"Feticide and Second Trimester Abortion," *Grand Rounds, Dept OB/GYN,* Boston Medical Center **May 2010**

"Sharing the Burden: Male Hormonal Contraception," *Grand Rounds, Dept OB/GYN* , Boston Medical Center **April 2010**

"Management of Retained Placenta in Second Trimester Abortion" *Grand Rounds, Dept OB/GYN* Boston Medical Center — **March 2009**

"The History of Abortion," *Grand Rounds Dept OB/GYN*, Boston Medical Center — **February 2009**

"Abortion for Labor and Delivery Nurses," *Dept of Nursing*, Boston Medical Center — **February 2009**

"Second Trimester Abortion" *Medical Students for Choice Annual Meeting*, St Louis, MO — **November 2008**

TEACHING

Thomas Jefferson Medical College

Resident Research Mentor — **August 2013 – present**

Mentor, Medical Students for Choice — **August 2013 – present**

Core Curriculum Committee, Dept OB/GYN Residency — **August 2013 – present**

Pritzker School of Medicine

"Reproductive Health: Clinical and Public Health Aspects of Contraception and Abortion:" pre-clinical elective for medical students

Course co-instructor — **March 2012 – June 2012**

EXPERIENCE

American Congress of Obstetricians and Gynecologists, Washington, DC

LARC Fellow, Advocacy Division — **September 2012**

Worked on promoting long-acting reversible contraception advocacy. Duties included blogging, visits with legislators on the hill regarding LARC coverage, reviewing professional education documents, attending committee meetings, and collecting information regarding state Medicaid coverage of LARC devices.

Medical Students for Choice, University of Arizona College of Medicine

Research Committee — **August 2006 – May 2007**

Analyzed data from 2006 National Annual meeting of Medical Students for Choice to determine if medical students interested in obstetrics and gynecology change their intent to provide abortions after the conference.

Arizona Family Planning Council, Phoenix, AZ

Research Assistant — **May 2004 – July 2004**

Designed and implemented survey regarding EC supply and provision by all Arizona pharmacies. Duties included literature search, survey construction, pharmacy communication and paper writing.

SERVICE

Medical Students for Choice — **June 2003 – May 2007**

Board of Directors — **May 2006 – May 2007**

Committee for Development of Strategic Plan

National Coordinator, Western Region — **May 2006 – May 2007**

Student Advisory Council — **May 2005 – May 2007**

Medical Students at Planned Parenthood, University of Arizona College of Medicine, Tucson, AZ

Student Volunteer — **August 2003 – May 2007**

Attended abortion clinics twice a month at local Planned Parenthood. Acted as patient advocate, attended informed consent session, conducted lab work, assisted procedure and supported the recovery room.

LANGUAGES

English – native language

Spanish – speak with proficiency

MEMBERSHIPS