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Application #: 255677

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

FULL LICENSE APPLICATION

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: [] U.S./Canadian Graduate [X] International Graduate

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

Lepore Timothy James Anthony
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

[X] M.D. [] D.O. [] Ph.D [] Other degree [X] Male [] 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 []

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

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

Place of Birth: Providence Rhode Island
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: 759 Chestnut St. Telephone: 1-413-794-5321
Number and Street

Springfield MA 01199
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: 1-413-794-8658

Are you applying for licensure through FCVS? (See instructions page 12) [X] Yes [] No

* The Board will use your Mailing Address for all correspondence