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Board of Registration in Medicine

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Application #: 250175
Date of Issue: __/__/__

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

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.

Check One: ☑ U.S./Canadian Graduate ☐ International Graduate

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

Khoury	Rasha	Saman	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☐ 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: _____ (City) _____ (State/Province/Territory) _____ (Country if not USA)

*Mailing Address: _____ (Number and Street) Telephone: _____

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

Home Address: _____ (Number and Street) Telephone: _____

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

Business Address: UCSF Dept of OB&GYN Rm 1483 (Number and Street) 505 Parnassus Ave Telephone: (415) 476-

San Francisco (City) CA (State/Province/Territory) 94143 (Zip (or postal) Code)

E-mail Address: _____ number: n/a

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☑ No

* The Board will use your Mailing Address for all correspondence

CK.# 251
12/05/11
W 2

PRINT NAME: Rasha Khoury

Pre-medical School

Facility: Georgetown University Degree: BS From 8/30/00 To 5/22/04
Street: 37th & O'St NW Washington City: Washington State: DC

Facility: _____ Degree: ____ __/__/__ __/__/____
Street: _____ City: _____ State: _____

Medical School

Facility: Yale School of Medicine Degree: MD From 9/01/04 To 5/16/08
Street: 333 Cedar St City: New Haven State: CT

Facility: _____ Degree: ____ __/__/__ __/__/____
Street: _____ City: _____ State: _____

Date of medical school graduation: 5 / 26 / 2006
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

From To

Facility: UCSF Position: PGY1 6/18/08 6/20/09
Street: 505 Parnassus Ave City: San Francisco State: CA

Facility: UCSF Position: PGY 2-4 6/21/09 present
Street: 505 parnassus Ave City: San Francisco State: CA

Facility: _____ Position: _____ __/__/__ __/__/__
Street _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/____
Street: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. 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, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information

Examination	Most Recent Date taken (Month/Year)	Passed (P)	or Failed (F)	Number of attempts
USMLE Step I	5/2006	☑ P	☐ F	1
USMLE Step II	CK 8/2007 + CS 6/2007	☑ P	☐ F	1
USMLE Step III	6/2009	☑ P	☐ F	1
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)	☐ P	☐ F	

PRINT NAME: Rasha Saman Khoury

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active 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: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
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: California (CA)

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

3. List Board Certification(s): _____ Certification date: __/__/__

   _____ Certification date: __/__/__

4. List your practice specialt(ies) Obstetrics + Gynecology

5. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: Starting fellowship in family planning at Harvard Medical School / Brigham + Women's Hospital

7. Name of Facility: Brigham + Women's Hospital
   Address: 75 Francis St City: Boston, MA 02115

8. Anticipated starting date in Massachusetts: 6/30/2012

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

MD

Signature of Applicant

11 / 22 / 2011
Month Day Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers were **required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: 1 6 5 9 6 0 9 9 0 7

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 11 / 22 / 11

Date prepared: 1/21/2012
Name: Rasha S. Khoury
Office Address (current): 505 Parnassus Ave. Room 1483 Box 0132. San Francisco, CA 94143
Office Address (future): One Brigham Circle, 4th Floor. Boston, MA 02120
Home Address:
Work Phone: (415) 476 5192
Work Email:
Work Fax: (415) 476 1811
Place of Birth:

Education

9/2000-5/2004	Bachelor of Science	Biology with a concentration in Cell and Microbiology (cum laude with distinction in the major)	Georgetown University
9/2004-5/2008	Doctor of Medicine	Medicine	Yale School of Medicine

Postdoctoral Training

6/2008-6/2009	Internship	Obstetrics and Gynecology	University of California San Francisco
7/2009-present	Residency	Obstetrics and Gynecology	University of California San Francisco
Anticipated (7/2012-7/2014)	*Joint Fellowship*	*Family Planning and Global Women's Health*	*Brigham and Women's Hospital*

Committee Service

9/2006-5/2008	Yale Arab Alumni Association	Yale University	Co-founder and former executive board member, Mentor and graduate student liaison
7/2010-7/2011	CIR/SEIU Delegate	San Francisco General Hospital	Committee for Interns and Residents

Professional Societies

7/2006-present	National Arab American Medical Association	Member
6/2008-present	American College of Obstetrics and Gynecology	Junior Fellow

Honors and Prizes

9/2000-5/2004	John Carroll Scholar	Georgetown University	Service
9/2003-5/2004	Sigma Xi Medal	Georgetown University Department of Biology	Outstanding research in the major

10/2009-present	Residency Selection Committee	University of California San Francisco	Member

Report of Funded and Unfunded Projects

Funding Information

Past (N/A)

Current (N/A)

Future (National Family Planning Fellowship)

Past and Current Unfunded Projects

10/2001-5/2004	BS Thesis: A Central Role for Microfilaments in the Attachment of *Giardia lamblia*, Georgetown University, Washington DC. PI: Heidi Elmendorf, PhD. *Giardia lamblia* cytoskeleton lab, Washington DC.
10-12/2006	Mental health in Beirut; stress inoculation or sensitization? American University of Beirut Medical Center, Beirut, Lebanon. *Research assistant.* PI: Dr. A Kazzi, AUBMC; Dr. G Larkin, YSM; Dr. R Smith, Mount Sinai SOM.
9/2007-5/2008	MD Thesis: Localized biliary ischemia in patients with hepatic arteriovenous malformations, a newly recognized syndrome occurring in Hereditary Hemorrhagic Telangiectasia; Diagnosis and Management. Submitted to the Yale School of Medicine in partial fulfillment of the requirements for the degree of Doctor of Medicine. PI. Robert White, MD. Hereditary Hemorrhagic Telangiectasia lab, New Haven, CT.
11/2010-present	In process: Reorienting Childbirth and Postpartum Care in the Occupied Palestinian Territories (OPT): an action oriented research study. Institute of Community and Public Health, Birzeit University, OPT.
11/2011-present	In process: Case Review of Hysterectomies for Transgender (Female to Male) Patients at San Francisco General Hospital. San Francisco, CA.

Current Licensure and Certification

12/2009-12/2013	California Medical License
1/2010-12/2013	Federal DEA Registered Practitioner
Anticipated 7/2012-7/2014	*Massachusetts Medical License (pending)*

Report of Education of Patients and Service to the Community

6/2004-6/2005	**Women's Center for Legal Aid and Counseling**, East Jerusalem. *Arabic-English Translator*
9/2005-5/2007	**Yale Law School Immigration Clinic**, New Haven, *CT. Arabic-English Translator*
10-11/2006	**Volunteer Outreach Clinic**, Shatila refugee camp, Beirut. *Physician assistant*
10-11/2006	**Popular Aid for Relief and Development (PARD) Women's Clinic**, Sabra, Beirut 9-11/2006. *Physician assistant and consultant*
9/2007-5/2008	**HAVEN Free Clinic**, Fair Haven, CT *Senior clinical team member*
6/2010-6/2011	**Women's Homeless Clinic**, San Francisco CA. *Medical student preceptor*
9/2010-present	**RECLAIM Health Collective**. *Member.* http://reclaimhealth.homestead.com/index.html
6-10/2011	The Brown Boi Project book on Health for the Masculine of Center. *Section Editor* http://brownboiproject.org/brownbois_bios.html

SUPPLEMENT FORM

PRINT NAME: Rasha Saman Khoury DATE: 11/22/11

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
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, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: _____ Date: 11/22/11

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to 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 related to professional competency or conduct 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 been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim 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?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: _____ Date: 11/22/11

Revised: 12.01.10

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

MEDICAL EDUCATION VERIFICATION

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

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: [signature] Date of Birth:

Print or Type Name: Khoury (Last name) Rasha (First Name) Suman (Middle Initial) Social Security No.

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

Name of Medical School: Yale School of Medicine

Address: 333 Cedar St City: New Haven State or Province: CT 06510

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine. (official transcript enclosed)

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: Georgetown University

Undergraduate School Address: 37th + O St NW Washington DC 20057

(Continued on page 2)

Enrollment and Participation: Our records indicate that ____Khoury _____ Rasha_____S.
(type or print the applicant's name): (Last name) (First name) (Middle initial)
attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:

FROM	TO	FROM	TO
09/07/2004	06/12/2005	06/19/2006	06/15/2007
09/06/2005	06/09/2006	06/18/2007	05/16/2008

The applicant attended __164____ total weeks or _____total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education

[X] was awarded a degree in __Doctor of Medicine____on (month/day/year) May 26, 2008

[ ] was NOT awarded degree Please explain in comments section _____

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

SEE ENCLOSED EXTENDED ENROLLMENT LETTER

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
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 TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Terri Tolson
Print Name: Terri Tolson

Title: Registrar

Date: December 8, 2011 telephone: (203) 785-2644

DATE: 12-14-11

INITIALS: _____

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.massmedboard.org

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] MD Date 11/22/11

Print or Type Name Rasha Saman Khoury

Name of Institution UCSF (University of California – San Francisco)

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 California, San Francisco If name of Institution was different when applicant attended, please enter name N/A

Enrollment and Participation: Our records indicate that Rasha Khoury (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
Internship	1	OB/GYN	6/18/08	6/20/09	yes	ACGME
Residency	2	OB/GYN	6/21/09	6/19/10	yes	ACGME
Residency	3	OB/GYN	6/20/10	6/18/11	yes	ACGME
Residency	4	OB/GYN	6/19/11	present	In Process	ACGME

(Continued on page 2)

APPLICANT'S NAME Rasha Khoury

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 _____

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 Amy M. Autry, MD

Academic Title Program Director

Telephone (415) 476-5192 Today's Date 11/22/2011

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

Seal Verified

DATE: 12-6-11

INITIALS: rcd

PRINT NAME: Rasha Saman Khoury

Pre-medical School

Facility: Georgetown University Degree: BS From 8/31/00 To 5/22/04
Street: 37th and O St N.W. City: Washington State: DC

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Medical School

Facility: Yale School of medicine Degree: MD From 8/31/04 To 5/26/08
Street: 333 Cedar Street City: New Haven State: CT

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 05 / 26 / 2008
Month Day Year

Note: U S graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

From To

Facility: UCSF (Univ. of California) Position: PGY 1 6/17/08 6/19/09
Street: 505 Parnassus Ave City: San Francisco State: CA

Facility: UCSF (Univ of California) Position: PGY 2-4 6/20/09 6/23/12
Street: 505 Parnassus Ave City: San Francisco State: CA

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

MALPRACTICE HISTORY

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

Please fax to Attention Krishna Doyle

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: **If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD.**

*** TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE. ***

Liability Carrier: UCSF Risk Management + Insurance Services From: 6/13/08 To: present (UCSF)
City: San Francisco State: CA 94143 Policy Number: N/A

Liability Carrier: UCSF Risk Management at SFGH From: 6/13/08 To: present (SFGH)
City: San Francisco State: CA 94110 Policy Number: N/A

Liability Carrier: _____ From: ___/___ To: ___/___
City _____ State _____ Policy Number: _____

Applicant's signature: _____ Date 12/27/2011

Print Name: Rashmi Kilowry MD CREOG Class of 2012

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

UCSF Risk Management + Insurance Services
2333 California St Suite 325 Box 1338
San Francisco CA 94143 (415) 476-2499

UCSF OB/GYN Residency

PRINT NAME: Rasha Khoury

Pre-medical School

Facility: Georgetown University Degree: BS From 8/30/00 To 5/12/04
Street: 37th & O'St NW Washington City: Washington State: DC

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Medical School

Facility: Yale School of Medicine Degree: MD From 8/31/04 To 5/16/08
Street: 333 Cedar St City: New Haven State: CT

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 5 / 26 / 2008
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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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. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

From To

Facility: UCSF Position: PGY 1 6/18/08 6/20/09
Street: 505 Parnassus Ave City: San Francisco State: CA

Facility: UCSF Position: PGY 2-4 6/21/09 Present
Street: 505 Parnassus Ave City: San Francisco State: CA

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Rasha S Khoury, M D **License No.:** 250175

Current Status: Active **License Expiration Date:** 12/21/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
1620 Tremont st
One Brigham Circle, 4th floor
Boston
Massachusetts - 02120
United States of America

Home Address:

Business Address:
1620 Tremont st
One Brigham Circle, 4th floor
Boston
Massachusetts - 02120
United States of America
(617) 732-8798

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
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

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

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
	None Reported

Physician Name: Rasha S Khoury, M D **License No.:** 250175

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 24 hrs/wk
b) outpatient care 16 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2012	12/31/2012	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 ever taken a leave of absence from any health care facility, group practice or employer?
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 CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, 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?**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Rasha S Khoury, M D **License No.:** 250175

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: Rasha S Khoury, M.D. **License No.:** 250175

Current Status: Active **License Expiration Date:** 12/21/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
1321 Upland Dr 4920
Houston
Texas - 77043
United States of America

Home Address:

Business Address:

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**
None Reported

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

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
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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?

Physician Name: Rasha S Khoury, M.D. **License No.:** 250175

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.**

APPLICANT'S NAME: Rasha Khoury

MA License Number: 252175
Date license revived ___/___/___

RECEIVED
MAR - 2 2016
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/massmedboard

LAPSED LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $700.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

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

Khoury	Rasha	S	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

Medical Degree: ☑ M.D. ☐ D.O. ☐ Ph.D. ☑ Other degree M.P.H

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: ___ ___ ___

National Provider Identifier (NPI) Number 1659609967

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

Home Address: _____ (Number and Street) _____

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

Business Address: 1321 Upland Dr. # 4920 (Number and Street)

Houston (City) TX (State/Province/Territory) 77043 (Zip (or postal) Code)

Business Telephone: (___) ___ ___. ext. ___ Home Telephone: (___) ___ ___

E-mail Address: _____ Fax Number: _____

Preferred Mailing Address: ☑ Business Address ☐ Home Address

APPLICANT'S NAME: Barbara Khoury

Postgraduate Education

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

			From	To
Facility: Yale School of Medicine	Position: Medical Student		8/2004	5/2008
Street: 333 Cedar St	City: New Haven	State: CT		
Facility: Univ of California San Francisco	Position: Resident		6/2008	6/2012
Street: 505 Parnassus Ave	City: San Francisco	State: CA		
Facility: San Francisco General Hospital	Position: Resident		6/2008	6/2012
Street: 1001 Potrero Ave 5F	City: San Francisco	State: CA		
Facility: Brigham & Women's Hospital	Position: Fellow		7/2012	7/2014
Street: 75 Francis St	City: Boston	State: MA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

Hospital Affiliations and Employment

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

(Locum work)

			From	To
Facility: Doctors without Borders	Position: Volunteer		7/2014	10/2014
Street: 333 7th Ave	City: NYC	State: NY		
Facility: Saint Joseph Hospital	Position: OB/Gyn		10/2014	present
Street: 13 Raphael Nesher Shtr	City: Jerusalem	State: Israel		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

APPLICANT'S NAME: Rasha Khoury

Medical Malpractice Information

My medical malpractice insurance coverage is by: ☑ Insurance carrier ☐ Letter of Credit

Print name of insurer: Madaree Insurance Agency (Ha-Yasha St 2 Tel Aviv Yafo)

Policy dates: From: 01/1/2015 To: 01/31/2017 as per attached coverage letter

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because:

☐ I am not involved in direct patient care ☐ Otherwise exempt

Explain exemption My MA license lapsed 21/12/2014. I did not have direct patient care responsibilities until April 6 2015 (when the department accepted it's first patient)

Continuing Professional Development (CPD) (formerly Continuing Medical Education)

Read instructions for CPD requirements on page 3 before completing.

Activity status: ☑ Active ☐ Exemption Currently active in ABOG MOC process (year 2)

Category 1 credits 161.75 Risk Management Category 1 5

Category 2 credits 60 Risk Management Category 2 5

see attached certificates for category I credits

Continuing Professional Development credit requirements must be completed before the lapsed license can be revived.

1. You must complete training to recognize and report suspected child abuse or neglect. Have you completed the required training? (See instructions.) ☑ Yes ☐ No (Your license will not processed until you complete the required training.) California (previous)
2. List other states (abbreviations) where you are currently or have ever been licensed: Israel (current)
3. A. Are you certified by the American Board of Medical Specialties (ABMS)? ☑ Yes ☐ No
   B. Are you certified by the American Osteopathic Association (AOA)? ☐ Yes ☑ No
4. List only ABMS certification(s): American board of OBGYN (active)
5. Reason for requesting revival of lapsed license in Massachusetts: I currently have an active general medical + specialist license in Israel but need to reactivate my US medical license for humanitarian work with Doctors Without Borders in emergency altruistic projects in countries where they need female gynecologists and do not accept Israeli medical licenses law requiring MA license revival for humanitarian work
6. **Please attach your current curriculum vitae listing the months and years of education, training, clinical activity and work history since your graduation from medical school.**

24/7/16

APPLICANT'S NAME: Aisha Henry

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

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

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 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.

Under the pains and penalties of perjury, I declare that I have examined this Lapsed License Application and all of 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: _____ Date: 10/2/16

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Commonwealth of Massachusetts – Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, Rasha Khoury
(type or print name)

certify, under the penalties of perjury, to the best of my knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: [signature] DATE: 16/2/16

Social Security Number: ____________ ____________

* *

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

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 form does not imply that you will participate in the Medicare program.

SIGNED: [signature] DATE: 16/2/16

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

✓ Participation in a Meaningful Use program as an eligible professional.
___ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program.
___ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
___ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

___ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4), or
___ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: _____ DATE: 12/2/16

Lesbia Khoury

PRINT NAME: Paola Hlavacy DATE: 6/2/16

LAPSED LICENSE APPLICATION SUPPLEMENT

PRINT NAME: Paola Hlavacy DATE: 6/2/16

IMPORTANT NOTES

For purposes of the following questions, the time period is from the time you signed your last Massachusetts license application to the present.

If you answer "yes" to any of these questions, you must provide the additional information on pages 5-9.

	QUESTIONS	**YES**	**NO**
1.	Have you been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
2.	Have you surrendered a license to practice medicine or any professional license or has your license or certificate been revoked? (You do not need to report a lapsed license.)		
3.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification been suspended or revoked?		
4.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
5-A.	Have you relinquished any medical staff membership or association with a health care facility?		
5-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility 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?		
5-C.	Have you withdrawn an application for hospital privileges or appointment, or have you 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?		
6.	Have you 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.)		

PRINT NAME: Rasha Khoury DATE: 12 . 2 . 14

		YES	NO
7	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
8.	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
9	Have you had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
10-A	Has any medical malpractice claim 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 ?		
10-B	Has any lawsuit, other than a medical malpractice suit, been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Rosita Ichaury DATE: 10 . 2 . 16

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 11 to 13. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application, it means recently enough to impact one's functioning as a physician

		YES	NO
11	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
12	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
13	Have you refused to submit to a test to determine whether you had consumed and or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-13 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Rosha Khoury DATE: 10 2 16

CERTIFICATIONS

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

SIGNATURE: DATE: 10 2 16

Rasha Khoury, MD MPH FACOG

Education

12/2014	Diplomat in the American College of Obstetrics & Gynecology
7/2012-5/2013	Master of Public Health (Clinical Effectiveness) Harvard School of Public Health. Boston MA, USA
8/2004-5/2008	Doctor of Medicine Yale School of Medicine. New Haven CT, USA
8/2000-5/2004	Bachelor of Science (Biology, concentration in Cell and Microbiology) Recipient of the Sigma Xi Medal for outstanding research in the major; John Carroll Service Scholar Georgetown University. Washington DC, USA

Professional experience

Field of expertise: Obstetrics and Gynecology

6/2008-6/2012	Internship and Residency in Obstetrics and Gynecology, Recipient of the James R Green MD Memorial Award for exemplary service of vulnerable women; Member of the Residency Selection Committee University of California, San Francisco CA, USA

Field of expertise: Family Planning

7/2012-6/2014	Joint Fellowship in Family Planning and Global Women's Health, Brigham and Women's Hospital/Harvard Medical School. Boston MA, USA
9/2012-6/2014	Staff Physician at Planned Parenthood League of Massachusetts, Boston MA
9/2012-6/2014	Staff Physician at Women's Health Services, Brookline MA

Current employment

1/2015-present	Associate Director of Obstetrics & Gynecology at Saint Joseph Hospital, Jerusalem (providing both obstetric and gynecologic outpatient and inpatient services as a full time employee)

7/2015-present	Macabi health services Obs&Gyn specialist for 5 East Jerusalem clinics (outpatient services and procedures)

Service

1/2013-2014	Physicians for Human Rights Asylum Network
3/2014-present	Médecins Sans Frontières -Volunteer ob/gyn (served as an emergency obstetric provider in Sierra Leone June-July 2014)
11/2014-present	Physicians for Human Rights -Israel (volunteer physician)
11/2014-present	Public Committee Against Torture (volunteer physician)

Relevant research and teaching experience

Research

9/2012-2014	Fellowship in Family Planning Independent Research: "Investigating the effect of a Community Health Worker led prenatal family planning counseling intervention on postpartum contraceptive use among postpartum women in the West Bank". Funding: Society for Family Planning. Mentors: Alisa Goldberg MD, MPH and Janet Rich-Edwards ScD, MPH. Local partners: Palestinian Community Health Worker Association, Palestinian Ministry of Health, Institute of Community and Public Health, Birzeit University, oPt.
11/2010-2014	"Investigating the acceptability, feasibility and effectiveness of clinical audit and feedback to decrease maternal morbidity and mortality at Ramallah Hospital, occupied Palestinian territories" (part of a 4 country study funded by the WHO) Middle East and North Africa Reproductive Health Working Group. Mentors: Laura Wick MA and Sahar Hassan MSN, Institute of Community and Public Health, Birzeit University, oPt.

Lectures

2012-2014	Harvard Resident Didactic Lectures, Boston MA, USA

• Learning From the Women Who Survive: Improving maternal health through clinical audit in the occupied Palestinian territories (BWH Resident didactics)
• Unsafe Abortion, a Global Perspective (BWH/MGH Global OBGYN Curriculum)
• Women's Health in the occupied Palestinian territories: the role of community-based participatory research (BIDMC Didactics)
• Beyond the Difficult Patient: Insights from Abortion Care (Family Planning Lecture Series, BWH)

• Update on Medication Abortion (Resident didactics)
• Ambulatory Gynecology CREOG review (Resident didactics)
• Community-Based Participatory Research and Women's Health (Resident didactics)
• Reviewing the Evidence on Second Trimester Induction of Labor (Joint Maternal Fetal Medicine -Family Planning Lecture series, BWH)
• Increasing postpartum contraception in Palestine: A cluster randomized trial (Fellowship in Family Planning and Society of Family Planning Annual Meeting. Chicago, IL)
• Abortion Dispatches from Around the Globe (Workshop) and Abortion How-To (Workshop) Civil Liberties and Public Policy Meeting: From Abortion Rights to Reproductive Justice. Hampshire College, MA
• Increasing postpartum contraception in Palestine: A cluster randomized trial (Workshop -The Lancet Palestine Health Alliance Meeting. Amman, Jordan)

Professional Societies

2012-present	Society for Family Planning (FP fellow)
2013-present	Association of Reproductive Health Professionals -Member
2014-present	American College of Obstetrics and Gynecology Fellow, Board certified

Languages

Bilingual Arabic/English (mother tongues)
Other: Hebrew, French and Spanish (working knowledge)

References:

1) Alisa Goldberg, MD MPH. Associate Professor of Obstetrics, Gynecology and Reproductive Biology. Director of Fellowship in Family Planning, Brigham and Women's Hospital. Connors Center for Women. One Brigham Circle, 4th Floor. Boston, MA 02120. Tel: +16177326987. Email: agoldberg@pplm.org
2) Paula Johnson, MD MPH. Professor of Medicine. Executive Director of the Connors Center for Women and Gender Biology. Brigham and Women's Hospital, PB 5-534, 15 Francis Street, Boston MA 02115. Tel: +16177328985. Email: pajohnson@partners.org
3) Phillip Darney, MD MSc. Distinguished Professor of Obstetrics, Gynecology and Reproductive Science. Director, UCSF Bixby Center for Global Reproductive Health. 3333 California Street, Suite 335, San Francisco CA 94143-0744. Tel: +14154764911. Email: darneyp@obgyn.ucsf.edu

Local references available on request

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Rasha Khoury
(type-print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine

I further request and authorize that the requested information, documents, and records be sent directly to

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers, 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers, and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Applicant's Signature — Date of Signature: 6/7/16

Khoury Rasha S
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month day year)