Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

Current Status: Active **License Expiration Date:** 9/29/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
119 Belmont Street
Worcester
Massachusetts - 01605
United States of America

REDACTED COPY

Home Address:

Business Address:
119 Belmont Street
Worcester
Massachusetts - 01605
United States of America
(508) 334-6449

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
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
	None Reported

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 8 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Commonwealth Professional Assurance Con	10/01/2012	10/01/2013	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?

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

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?

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

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: Tara N Kumaraswami, M.D. **License No.:** 253191

Current Status: Active **License Expiration Date:** 9/29/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
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United States of America

Home Address:

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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
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
University Of Massachusetts - Memorial Campus	

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 8 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Commonwealth Professional Assurance Con	10/01/2014	10/01/2015	Claims made with tail coverage
Commonwealth Professional Assurance Con	10/01/2015	10/01/2016	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?

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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?

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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?
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a) Have you been charged with any criminal offense during this period?
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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?

Physician Name: Tara N Kumaraswami, M.D. **License No.:** 253191

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.

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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.

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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.

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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

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United States of America

Home Address:

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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.

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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.**

SUPPLEMENT FORM

PRINT NAME: Tara N. Kumaraswamy DATE: 5/29/12

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 or remediation by a medical school or any postgraduate training program?		
3. If you are a US 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 cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: any Step of the USMLE, NBOME, FLEX, any State Board examination, any part of the National Boards, 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: Tara Kumaraswamy Date: 5/29/12

		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 termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid; or have you ever been restricted from receiving payments from any Medicare, Medicaid (any state), or third party payors?		
14.	Have you ever had an application for membership as a participating provider rejected by any third-party payor?		
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: Jura Ramanathan **Date:** 5/25/12

CONFIDENTIAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplemental pages for questions #16 to 18. 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 have an impact on one's functioning as a licensee, or within the past two years of this application.

		YES	NO
16.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
17-A.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently impaired or limited?		
17-B.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
18.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		

If your responses to Questions 1-18 change while your application is pending, you must immediately notify the Board of the new information.

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. To the best of my knowledge, I meet the qualifications for full licensure in Massachusetts.

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

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.

Applicant's Signature: Ina Hamamoran Date: 5/25/12

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

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 Tara Kumaraswami Date of Birth

Print or Type Name: Kumaraswami (Last name), Tara (First Name), N (Middle Initial) Social Security No.

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

Name of Medical School: University of Massachusetts Medical School

Address: 55 Lake Avenue North City: Worcester State or Province MA

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.

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? [X] Yes [ ] No

If "yes," indicate where the applicant completed premedical school:

Applicant's Undergraduate School: U. of Massachusetts, Amherst

Undergraduate School Address: Amherst, MA

(Continued on page 2)

Enrollment and Participation: Our records indicate that

Kumaraswami (Last name) Tara (First name) N. (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
	08/ 12 / 02	06/ 09/ 03	07/ 05 / 05	06/ 04/ 06
	08/ 11 / 03	05/ 28/ 04	/ /	/ /
	07/ 06 / 04	06/ 24/ 05	/ /	/ /

The applicant attended 162 total weeks or 38 total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one [X] was awarded a degree in Medicine on (month/day/year) 06 / 04 / 06

[ ] was NOT awarded degree. Please explain reason(s).

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?		
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: Michael F Baker

Print Name: Michael F. Baker, M.A.

Title: Registrar

Date: 06 / 01 / 12 Telephone: (508) 856-2267

E-mail address: registrar@umassmed.edu

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

Seal Verified

DATE: 6/4/12

INITIALS: JDC

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: Tara Kumarasuam Date: 5/16/12

Print or Type Name: Tara N. Kumarasuami

Name of Institution: University of Massachusetts

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 Massachusetts If name of Institution was different when applicant attended, please enter name.

Enrollment and Participation: Our records indicate that Tara Kumarasuami (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	07/01/06	06/30/07	Y	ACGME
Residency	2	OB/GYN	07/01/07	06/30/08	Y	ACGME
Residency	3	OB/GYN	07/01/08	06/30/09	Y	ACGME
Chief Residency	4	OB/GYN	07/01/09	06/30/10	Y	ACGME

(Continued on page 2)

APPLICANT'S NAME: [illegible]

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:_____

_____

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

AFFIX SEAL

(If the information is not sealed, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: Petra H. Belady M.D

Academic Title: Assistant Professor

Telephone: (508) 334-6507 Today's Date: 5.23.12

E-mail address: petra.belady@umassmemorial.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: 6/5/2012

INITIALS: CJM

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: Tara Kumaraswami Date: 6/19/12

Print or Type Name: Tara Kumaraswami

Name of Institution: University of Illinois

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 Illinois Hospital and Health Sciences System

If name of Institution was different when applicant attended, please enter name: University of Illinois at Chicago

Enrollment and Participation: Our records indicate that Tara Kumaraswami (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	Obstetrics and Gynecology / Family Planning	7/1/10	6/30/12	YES	Not accredited

(Continued on page 2)

APPLICANT'S NAME: [redacted]

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 not 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).

Shannon Dowty 6/19/2012

OFFICIAL SEAL
SHANNON DOWTY
Notary Public - State of Illinois
My Commission Expires Nov 6, 2012

Program Director's Signature: A Cowett (Associate Program Director)

Print Name: Allison Cowett

Academic Title: Assistant Professor, Associate Director Family Planning Fellowship

Telephone: (312) 996-2242 Today's Date: 6/19/12

E-mail address: acowett@uic.edu

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL 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 www.mass.gov/masssmedboard

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 completed 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: UMass Memorial Healthcare (Self-Insurance Program, Inc.) From: 7/06 To: 6/10
City: Worcester State: MA Policy Number: HL101

Liability Carrier: University of Illinois (Self Insured Plan) From: 7/10 To: 6/12
City: Urbana State: IL Policy Number: U1-SIP-001

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

Applicant's signature: Tara Kumaraswami 5/29/12
Date

Print Name: Tara Kumaraswami

Address: _____ City: _____

State: _____ Zip code: _____

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for a substantial period of time and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH

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)ne

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Tara N Kumaraswami
(name of applicant)

for 5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

Signature of Certifying Physician

230024 License Number

MA State

Petra H Belady MD
Type or print name clearly

Address: 119 Belmont St.
City: Worcester
State: MA Zip: 01605
Telephone: (508) 334-6507
Date: 5/23/12

Signature of Notary

11/6/2012
My commission expires

OFFICIAL SEAL
SHANNON DOWTY
Notary Public - State of Illinois
My Commission Expires Nov 6, 2012

DAWN K FRAGA
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
June 24, 2016

05/24/12

Instructions to the certifying physician: Return the completed form to the applicant in a sealed envelope with your signature across the seal.

Seal Verified
DATE: 6/5/2012
INITIALS: CMJ

Tara Kumaraswami, MD
Curriculum Vitae

Personal Information

Office Address: Department of Obstetrics and Gynecology
University of Illinois at Chicago
820 South Wood Street, M/C 808
Chicago, Illinois 60612

Email
Phone

Current Titles and Affiliation

July 2010-present **Fellow in Family Planning**
Department of Obstetrics and Gynecology
University of Illinois at Chicago College of Medicine

Education and Training

Education

September 1998-June 2002 **Bachelor of Science in Biology, *summa cum laude***

University of Massachusetts - Amherst
Amherst, Massachusetts

August 2002-June 2006 **Doctor of Medicine**

University of Massachusetts Medical School
Worcester, Massachusetts

July 2006-June 2010 **Residency Training in Obstetrics and Gynecology**

Department of Obstetrics and Gynecology
University of Massachusetts Medical School
Worcester, Massachusetts

July 2010-present	**Fellowship in Family Planning** Department of Obstetrics and Gynecology University of Illinois at Chicago College of Medicine Chicago, Illinois
August 2010- May 2012	**Masters in Public Health** University of Illinois Program in Public Health Chicago, Illinois

Training

August 2011- June 2012	**Physicians for Reproductive Health and Choice** Leadership Training Academy

Honors and Awards

2010	**The Bahy Louca Award for Humanitarianism in Medicine** Department of Obstetrics and Gynecology University of Massachusetts Medical School
2010	**Paul Briscoli Award for Resident – Faculty Academic Research Collaboration** Awarded by the Department of Psychiatry at the University of Massachusetts Medical School
2009-2010	**Outstanding House Officer Award** University of Massachusetts Medical School Faculty
2009	**Resident Teacher Award** University of Massachusetts Medical School Class of 2009
2007-2010	**Golden Apple Award for Outstanding and Dedicated Teaching of Medical Students** Awarded by third-year medical students at the University of Massachusetts Medical School
2002	**Summa Cum Laude**

University of Massachusetts - Amherst

2001-2002 **Junior Fellows**
University of Massachusetts - Amherst

2001 **Phi Beta Kappa**
University of Massachusetts - Amherst

Licensure and Certification

2010-present Licensed Physician and Surgeon, State of Illinois
2010-present DEA Registration

Academic Appointments

2010-present **Family Planning Fellow/Clinical Instructor**
Department of Obstetrics and Gynecology
University of Illinois at Chicago College of Medicine
Chicago, Illinois

2009–2010 **Administrative Obstetrics and Gynecology Chief Resident**
Department of Obstetrics and Gynecology
University of Massachusetts Medical School
Worcester, Massachusetts

Teaching Responsibilities

Courses taught

2010- present **Residency Training in Family Planning**
Instruction of first and third-year residents in the clinical portions of the Family Planning curriculum

2006 **Physical Diagnosis Course**
Instructed first year medical students in physical exam

techniques

Lecturing

2010- present **Medical Student Lecture Series**
Given each rotation to students in the Obstetrics and Gynecology Third-Year Clerkship
- Case Studies in Contraception
-Lectures on Miscarriage, Ectopic, Molar Pregnancy and Abortion

Administrative Responsibilities/Service

Department

2010 - present **Member, Residency Education Committee**
University of Illinois Medical Center at Chicago

Hospital

2008 - 2010 **Member, Surgical Site Infection Committee**
University of Massachusetts Medical Center

Community/Public Service

2011 - present **Volunteer, Horizons for Youth**
Chicago, IL
Seminar about contraception, pregnancy, sex and abortion for teen participants and their mentors at their youth enrichment program.

2002 - 2006 **Volunteer, Pathways Serving the Underserved**
University of Massachusetts Medical School
Worcester, Massachusetts
Through international and domestic experiences and seminars, the program develops students' linguistic and cultural competence and sensitivity to the hardships that many immigrants and poor people face.

1999 – 2002 **Volunteer, Everywoman's Center**
The Rape Crisis Center of Western Massachusetts
Amherst, Massachusetts
Certified as a rape crisis counselor in Massachusetts. Staffed 24 hour hotline, ran teen support groups and one on one counseling sessions.

Global Health Service/Experiences

July – August 2011 **Consultant, International Planned Parenthood Federation at the South Asia Regional Office**
Delhi, India and Dhaka, Bangladesh
Developed clinical guidelines for the management of incomplete abortion and possible associated complications and developed a conference for mid-level providers.

May - August 2009 **Volunteer, American Friends of Kenya**
Nairobi, Kenya
Developed and implemented a program that provided pelvic exams, pap smears, STI screening and treatment and education about women's health in Nairobi and trained providers to continue the work.

April 2006 **Immersion Program, Cuenca, Ecuador**
Medical Spanish course in combined with a homestay experience and travel.

Summer 2003 **Immersion Program, San Jose, Guatemala**
Spanish language course, homestay experience and travel.

Society Memberships

2006 - present Junior Fellow, American Congress of Obstetricians and Gynecologists

2010 - present Junior Fellow, Society of Family Planning

2010 - present Member, Association of Reproductive Health Professionals

2010 - present Member, National Abortion Federation

Editorial Activities

2010 - present **Reviewer**
American Journal of Obstetrics and Gynecology

2010 - present **Reviewer**
Faculty 1000

Research

Grant Funding

September 2011 – July 2012 **Principal Investigator**
Postpartum Contraception: How can we improve counseling and provision? A pilot study of contraceptive counseling in a new setting. Society of Family Planning Research Grant
$55,000

Research Collaborations

July 2010 – March 2011 **Study Physician**
Gynuity study: Topical estriol for vaginal health
As a study physician I conducted research colposcopy on participants.

Publications

Book Chapters

1 **Kumaraswami T,** Cagianno, M. Vaginitis and Vaginosis. Domino F et al (eds) 5 Minute Clinical Consult. Lipincott: 2011. pages 1396-1397.

Abstracts

1 **Kumaraswami T,** Harwood B. Postpartum Contraception: What can we do to improve counseling and provision? Family Planning Fellowship Annual Meeting, San Diego, May 2012

2 **Kumaraswami T,** Burpee S, Liao X, Deligiannidis K, Howe A, Seligowski A, Jackson S, Moore Simas Impact of an Educational Intervention on Help Seeking Behaviors for Postpartum Depression: RCT. Poster Presentation. ACOG Annual Meeting, San Francisco, CA, May 2010

3 **Kumaraswami T**, Peskin E. Emergency Contraception: Availability and Awareness. University of Massachusetts Medical School. Summer Research Program Research Presentation, August 2006.

Works in Progress

1 **Kumaraswami T,** Burpee S, Liao X, Deligiannidis K, Howe A, Seligowski A, Jackson S, Moore Simas Impact of an Educational Intervention on Help Seeking Behaviors for Postpartum Depression: RCT. In progress.

2 **Kumaraswami T.** Management of Incomplete Abortion and Possible Associated Complications in Bangladesh. International Planned Parenthood Federation. In progress.

Invited presentations

1 **Breaking the Silence: Intimate Partner Violence in Pregnancy**
Department of Obstetrics and Gynecology Grand Rounds
University of Massachusetts Medical School
Worcester, Massachusetts, March 2009

2 **Study Design and RCTs**
Guest Lecturer Advanced Epidemiology Course
Master of Science in Clinical Investigation
University of Massachusetts Medical School
Worcester, Massachusetts, April 2009

3 **Postpartum Depression: What We Can Do.**
Department of Obstetrics and Gynecology Grand Rounds
University of Massachusetts Medical School
Worcester, Massachusetts, October 2009

4 **Pre and Post Menstrual Regulation Counseling.**
Family Planning Association of Bangladesh
International Planned Parenthood Federation
Dhaka, Bangladesh, August 2011

5 **Technical Updates on Contraceptive Methods and Post Menstrual Regulation Contraception.**
Family Planning Association of Bangladesh
International Planned Parenthood Federation
Dhaka, Bangladesh, August 2011

6 **Manual Vacuum Aspiration for Management of Incomplete Abortion.**
Family Planning Association of Bangladesh
International Planned Parenthood Federation
Dhaka, Bangladesh, August 2011

7 **Manual Vacuum Aspiration Training, Hands on Training with Pelvic Models.**
Family Planning Association of Bangladesh
International Planned Parenthood Federation
Dhaka, Bangladesh, August 2011

8 **Family Planning**
Department of Obstetrics and Gynecology Family Planning Seminar
Loyola University School of Medicine
Maywood, IL, October 2011

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

I, Tara N Kumaraswami,
(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: Tara Kumaraswami DATE: 5/29/12

Social Security Number: _____

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.04 (2) (k) 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: Tara Kumaraswami DATE: 5/29/12

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Pat Quinn
Governor

Brent E. Adams
Secretary

Jay Stewart
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

BOARD OF REGISTRATION
IN MEDICINE
200 HARVARD MILL SQUARE STE 330
WAKEFIELD, MA 01888

Licensee:	TARA N KUMARASWAMI MD
License Number:	036.125298
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	03/25/2010
Expiration Date:	07/31/2014
License Status:	ACTIVE
License Method:	ACCEPT EXAM - USMLE
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

S E A L

Jay Stewart
Director
Division of Professional Regulation

May 21, 2012
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

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

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: Tara Kumarasami Date: 5 / 16 / 12

Print or type name: Tara N Kumarasami

License number: 036.125296 Status of license: IL ☒ 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.

Application #: 253491

RECEIVED JUN - 2012

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 ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

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

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

Kumaraswami	Tara	Neubert	
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: ___ ___ Social Security Number: ___ ___
Month Day Year

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: 820 South Wood Street Telephone: 312-413-9280
Number and Street

Chicago	IL	60612
City	State/Province/Territory	Zip (or postal) Code

E-mail Address: _____ Fax number: 312-413-0299

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

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

Pre-medical School

				From	To
Facility: University of Massachusetts	Degree: BS			9/1/98	5/22/02
Street: Massachusetts Avenue	City: Amherst	State: MA			
Facility:	Degree:			__/__/__	__/__/__
Street:	City:	State:			

Medical School

				From	To
Facility: University of Massachusetts	Degree: MD			8/1/02	6/4/06
Street: 55 Lake Avenue North	City: Worcester	State: MA			
Facility:	Degree:			__/__/__	__/__/__
Street:	City:	State:			

Date of medical school graduation: 6/2006
Month 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: University of Massachusetts	Position: PGY 1-4 Resident		7/1/06	6/30/10
Street: Belmont Street	City: Worcester	State: MA		
Facility: University of Illinois	Position: Fellow		7/1/10	8/30/12
Street: South Wood Street	City: Chicago	State: IL		
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	6/14/2004	☒ P	☐ F	1
USMLE Step II	7/29/2005	☒ P	☐ F	1
USMLE Step III	10/3/2007	☒ 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	

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: University of Massachusetts	Position: Resident		7/1/06	6/20/10
Street: Belmont Street	City: Worcester	State: MA		
Facility: University of Illinois	Position: Fellow		7/1/10	6/30/12
Street: 820 South Wood Street	City: Chicago	State: IL		
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: Illinois

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 and Gynecology

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

6. Reason for requesting a Massachusetts medical license: Joining a practice at the University of Massachusetts

7. Name of Facility: University of Massachusetts
   Address: 119 Belmont Street City: Worcester

8. Anticipated starting date in Massachusetts: 9/4/12

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. 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.

[signature] 5/29/12

Signature of Applicant Month Day Year

(Continued on page 5)

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 1 4 9 3 7 3 1 8 4

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: Jana Fernandes Date: 5/29/12

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Tara N Kumaraswami
(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.

Tara Kumaraswami — Applicant's Signature

5/29/12 — Date of Signature

Kumaraswami, Tara N
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)