Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Zevidah Vickery, M.D. **License No.:** 252675

Current Status: Active **License Expiration Date:** 10/14/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

REDACTED COPY

Home Address:

Business Address:

Riverbend Medical Associates
1109 Granby Road
Chicopee
Massachusetts - 01020
United States of America
(413) 789-6800

3) **Email Address:**

4) **Fax Number:** (314) 361-8359

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**
Missouri

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
Riverbend Medical Group	Agawam, MA

Physician Name: Zevidah Vickery, M.D. **License No.:** 252675

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 24 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Stella Maris Ins. Co., Ltd.	12/01/2012	12/01/2013	Occurrence Policy

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: Zevidah Vickery, M.D. **License No.:** 252675

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: Zevidah Vickery, M.D. **License No.:** 252675

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: Zevidah Vickery, M.D. **License No.:** 252675

Current Status: Active **License Expiration Date:** 10/14/2017

1) **Activity Status:** Inactive

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
1385 Highway 35 #147
Middletown
New Jersey - 07748
United States of America
(732) 842-9300

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**
Maryland
New Jersey
New York

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

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

This question does not apply to inactive physicians.

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

This question does not apply to inactive physicians.

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.

This question does not apply to inactive physicians.

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: Zevidah Vickery, M.D. **License No.:** 252675

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: Zevidah Vickery, M.D. **License No.:** 252675

Current Status: Active **License Expiration Date:** 10/14/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
SUNY Upstate Medical University
OB/GYN Associates 725 Irving Street Suite 600
Syracuse
New York - 13210
United States of America
(315) 464-5701

3) **Email Address:**

4) **Fax Number:** (315) 470-2868

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**
New York

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

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?

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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: Zevidah Vickery, M.D. **License No.:** 252675

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.

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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.**

Curriculum Vitae
Zevidah Vickery, MD

Date: Feb 1, 2012

Citizenship: USA
Address:
(Office) Women's Health Section
Myrtle Hilliard Davis Comprehensive Health Center
5471 Dr. Martin Luther King, Jr. Drive
St. Louis, MO 63112 USA
Telephone: (314) 367-5820 x2325
Email:

(Home)

Present Position: Generalist Obstetrician-Gynecologist, Myrtle Hilliard Davis Comprehensive Health Center

Education & Training:

2009-Present	Master of Science in Clinical Investigation Washington University School of Medicine St. Louis, MO completion May, 2012
2009-2011	Fellowship of Family Planning Washington University School of Medicine Department of Obstetrics and Gynecology St. Louis, MO
2005-2009	Internship and Residency Department of Obstetrics and Gynecology Beth Israel Medical Center Manhattan Campus of Albert Einstein College of Medicine New York, NY
2001-2005	Medical School for International Health in collaboration with Columbia University College of Physicians & Surgeons Ben Gurion University of the Negev Doctorate of Medicine Beersheva, IL
1998-2000	University of Washington Post-baccalaureate premedical studies Seattle, WA

1988-1992	University of Massachusetts B.A. Human Sexuality Education & Counseling, Women's Studies Amherst, MA

Academic Positions / Employment:

2009-2011	Clinical Fellow, Family Planning, Department of Obstetrics & Gynecology, Washington University School of Medicine
2003-2005	Research Assistant Department of Geriatrics Soroka Medical Center Ben Gurion University of the Negev
1992-2000	Medical Assistant Cedar River Clinic, University of Washington Medical Center, Northwest Kidney Centers Seattle, WA

Medical Licensure:

Missouri # 2009013466
Massachusetts PENDING

Honors and Awards:

2009-2010 Annual Fellow Resident Teaching recognition
2008-2009 Administrative Chief Resident
2006-2008 Annual Resident Teaching Award

Editorial Responsibilities:

Peer reviewer for *Contraception*

Professional Societies and Organizations:

American College of Obstetricians and Gynecologists, Junior Fellow
Society of Family Planning, Junior Fellow
Association of Reproductive Health Professionals
Physicians for Reproductive Choice and Health
American Medical Association
American Medical Women's Association

Clinical Title and Responsibilities:

Generalist obstetrician-gynecologist: out-patient and in-patient management of full range of obstetrical and gynecological issues, work collaboratively with WHNP in-office, participate in call pool with one other generalist, administrative duties as

assigned by Chief Medical Officer

Bibliography:

Current research:
Weight change in users' of progestin-only long-acting reversible contraception. *Submitted for publication.*

Articles:
Vickery, Z. Madden. T. *In the Trenches: Difficult IUC Insertion.* Obstetrics & Gynecology. 2011 Feb: 17(2):391-95.

Eisenberg DL, Allsworth JE, Vickery Z, Schaecher CP, Ogutha JO. *Roundtable Discussion: 'Recommendations for intrauterine contraception' by Dehlendorf et al.* Am J Obstet Gynecol. 2010 Oct: 203(4):319.e108.

MacIsaac, L., Vickery, Z. *Routine training is not enough: structured training in family planning and abortion improves residents' competency scores and intentions to provide abortion after graduation more than ad hoc training.* Contraception. 2011 Aug: *epub.*

Posters/abstracts:
Vickery Z, Madden T, Secura G, Allsworth J, Nash L, Zhao Q, Peipert JF. Weight change in users of three progestin-only contraception methods. Society of Family Planning's North American Forum on Family Planning. Oct 2011 (Washington. DC).

MacIsaac L., Vickery Z. *Impact of a specialty rotation in family planning on obstetrics and gynecology residents' self-assessment of competency and intentions to provide abortion services after graduation.* Contraception August 2010: 82(2): 208-209. Presented at: Women's Health 2009: the 17th Annual Congress (Williamsburg, VA), and The 8th Annual European Congress on Menopause (London, UK).

Reviews:
Vickery Z. Review of *Contraception Pocketcard Set.* Doody's Review Service (on-line). Available: http://www.doody.com.

Vickery, Z. Review of *Safety and bleeding profile of continuous levonorgestrel 90 mu-g EE 20 mu-g based on 2 years of clinical trial data in Canada* for Contraception.

Chapters:
Sexual Dysfunction. Guidelines for Women's Health Care. A Resource Manual. 4th ed. American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Invited Lectureships:

2011 *Contraception Discontinuation.* Grand Rounds. Department of Obstetrics & Gynecology, Washington University School of Medicine. St. Louis. MO

Weight change in users of three progestin-only contraception methods. Fellowship of Family Planning Annual Meeting. Washington. DC.

Weight change in users of three progestin-only contraception methods. Washington University School of Medicine Clinical Research Training Center Scholar Seminar. St. Louis. MO

2010 *The Public Health Impact of HPV Vaccines.* Epidemiology of Infectious Disease course, offered through Brown School of Public Health. Washington University in St. Louis. St. Louis. MO

Comparison of weight change in user's of three progestin-only methods of contraception during 12 months of use. Fellowship of Family Planning Annual Meeting. San Francisco. CA

Reproductive Healthcare is a Human Right. Health And Human Rights course for medical students. Washington University School of Medicine. St. Louis. MO.

2009 *Weight Change and Use of Etonorgestrel Subdermal Implant.* Washington University School of Medicine Clinical Research Training Center Scholar Seminar. St. Louis. MO

Genital Herpes. STD Intensive Course. St. Louis STD/HIV Prevention Training Center lecture series. St. Louis. MO

Intimate Partner Violence and Reproductive Health. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology. St. Louis. MO.

Cesarean Delivery. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology. St. Louis. MO.

Common Gynecologic Complaints. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology. St. Louis. MO

Healthcare in Ethiopia: My Personal Experience. Healthcare Disparities, a course in the Master's of Science in Health Care Services. University of Washington University College, St. Louis, MO

2004 Abortion & Contraception in the US. Medical student lecture. Ben Gurion University of the Negev Medical School for International Health.

Other Educational Activity:

2010 Consultant, Resident Peer Health Advisors providing in-dormitory sex education Undergraduate Student Health at Washington University in St. Louis

2010 Preceptor, 3rd year medical students, obstetrics and gynecology clinical Rotation, Washington University School of Medicine

Curriculum Vitae
Zevidah Vickery, MD

Date: July 18, 2012

Citizenship: USA

Address:
(Office) Women's Health Section
Myrtle Hilliard Davis Comprehensive Health Center
5471 Dr. Martin Luther King, Jr. Drive
St. Louis, MO 63112 USA
Telephone: (314) 367-5820 x2325
Email:

(Home)

Present Position: Generalist Obstetrician-Gynecologist, Myrtle Hilliard Davis Comprehensive Health Center

Education & Training:

July 2009-June 2012 Master of Science in Clinical Investigation
Washington University School of Medicine
St. Louis, MO degree awarded May 2012

July 2009-June 2011 Fellowship of Family Planning
Washington University School of Medicine
Department of Obstetrics and Gynecology
St. Louis, MO

July 2005-June 2009 Internship and Residency
Department of Obstetrics and Gynecology
Beth Israel Medical Center
Manhattan Campus of Albert Einstein College of Medicine
New York, NY

July 2001-June 2005 Medical School for International Health in collaboration with
Columbia University College of Physicians & Surgeons
Ben Gurion University of the Negev
Doctorate of Medicine
Beersheva, IL

Sep 1998- Apr 2000 University of Washington
Post-baccalaureate premedical studies
Seattle, WA

Sep 1988-May 1992 University of Massachusetts
B.A. Human Sexuality Education & Counseling, Women's Studies
Amherst, MA

Academic Positions / Employment:

July 2009-June 2011 Clinical Fellow, Washington University School of Medicine

July 2003-May 2005 Research Assistant
Department of Geriatrics
Soroka Medical Center
Ben Gurion University of the Negev

Aug1992-Dec 2000 Employment as Medical Assistant at
Cedar River Clinic, University of Washington Medical Center,
& Northwest Kidney Centers
Seattle, WA

Medical Licensure:
Missouri # 2009013466

Honors and Awards:
2008-2009 Administrative Chief Resident
2006-2008 Annual Resident Teaching Award

Editorial Responsibilities:
Peer reviewer for *Contraception*

Professional Societies and Organizations:
American College of Obstetricians and Gynecologists, Junior Fellow
Society of Family Planning, Junior Fellow
Association of Reproductive Health Professionals
Physicians for Reproductive Choice and Health
American Medical Association
American Medical Women's Association

Clinical Title and Responsibilities:
Generalist obstetrician-gynecologist: out-patient and in-patient management of full range of obstetrical and gynecological issues, work collaboratively with WHNP in-office, participate in call pool with one other generalist, administrative duties as assigned by Chief Medical Officer

Bibliography:

Current research:

Weight change in users' of progestin-only long-acting reversible contraception. *Submitted for publication.*

Articles:

Vickery, Z, Madden, T. *In the Trenches: Difficult IUC Insertion.* Obstetrics & Gynecology. 2011 Feb; 17(2):391-95.

Eisenberg DL, Allsworth JE, Vickery Z, Schaecher CP, Ogutha JO. *Roundtable Discussion: 'Recommendations for intrauterine contraception' by Dehlendorf et al.* Am J Obstet Gynecol. 2010 Oct; 203(4):319.e108.

MacIsaac, L, Vickery, Z. *Routine training is not enough: structured training in family planning and abortion improves residents' competency scores and intentions to provide abortion after graduation more than ad hoc training.* Contraception. 2011 Aug; *epub.*

Posters/abstracts:

Vickery Z, Madden T, Secura G, Allsworth J, Nash L, Zhao Q, Peipert JF. Weight change in users of three progestin-only contraception methods. Society of Family Planning's North American Forum on Family Planning, Oct 2011 (Washington, DC).

MacIsaac L, Vickery Z. *Impact of a specialty rotation in family planning on obstetrics and gynecology residents' self-assessment of competency and intentions to provide abortion services after graduation.* Contraception August 2010; 82(2): 208-209. Presented at: Women's Health 2009: the 17th Annual Congress (Williamsburg, VA), and The 8th Annual European Congress on Menopause (London, UK).

Reviews:

Vickery Z. Review of *Contraception Pocketcard Set.* Doody's Review Service (on-line). Available: http://www.doody.com.

Vickery, Z. Review of *Safety and bleeding profile of continuous levonorgestrel 90 mu-g/EE 20 mu-g based on 2 years of clinical trial data in Canada* for Contraception.

Chapters:

Sexual Dysfunction. Guidelines for Women's Health Care, A Resource Manual. 4th ed. American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Invited Lectureships:

2011 *Contraception Discontinuation*. Grand Rounds, Department of Obstetrics & Gynecology, Washington University School of Medicine, St. Louis, MO

Weight change in users of three progestin-only contraception methods. Fellowship of Family Planning Annual Meeting, Washington, DC.

Weight change in users of three progestin-only contraception methods. Washington University School of Medicine Clinical Research Training Center Scholar Seminar, St. Louis, MO

2010 *The Public Health Impact of HPV Vaccines*. Epidemiology of Infectious Disease course, offered through Brown School of Public Health, Washington University in St. Louis, St. Louis, MO

Comparison of weight change in user's of three progestin-only methods of contraception during 12 months of use. Fellowship of Family Planning Annual Meeting, San Francisco, CA

Reproductive Healthcare is a Human Right. Health And Human Rights course for medical students, Washington University School of Medicine, St. Louis, MO.

2009 *Weight Change and Use of Etonorgestrel Subdermal Implant*. Washington University School of Medicine Clinical Research Training Center Scholar Seminar, St. Louis, MO

Genital Herpes. STD Intensive Course, St. Louis STD/HIV Prevention Training Center lecture series, St. Louis, MO

Intimate Partner Violence and Reproductive Health. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology, St. Louis, MO.

Cesarean Delivery. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology, St. Louis, MO.

Common Gynecologic Complaints. CHOICE Project research assistants' clinical update. University of Washington Department of Obstetrics and Gynecology, St. Louis, MO

Healthcare in Ethiopia: My Personal Experience. Healthcare Disparities, a course in the Master's of Science in Health Care Services. University of Washington University College, St. Louis, MO

2004 Abortion & Contraception in the US. Medical student lecture, Ben Gurion University of the Negev Medical School for International Health.

Other Educational Activity:

2010 Consultant, Resident Peer Health Advisors providing in-dormitory sex education Undergraduate Student Health at Washington University in St. Louis

2010 Preceptor, 3rd year medical students, obstetrics and gynecology clinical Rotation, Washington University School of 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/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: HOSPITAL INSURANCE CO., INC From: 7/05 To: 6/09
City: WHITE PLAINS State: NY Policy Number: _____

Liability Carrier: WASHINGTON UNIV From: 07/09 To: / (PRESENT)
City: ST. LOUIS State: MO Policy Number: _____

Liability Carrier: FTCA DEEMING NOTICE From: 01/12 To: 12/12
City: ST. LOUIS State: MO Policy Number: _____

Applicant's signature: _____ 4/17/12 Date

Print Name: ZENDAH VICKERY

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 www.massmedboard.org

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.

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

ZEVIDAH VICKERY
(name of applicant)

for 11 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

Signature of Certifying Physician

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

D0070371 — License Number

MD — State

Stella Blosser
Type or print name clearly

Signature of Notary

Address:
City:
State: Zip:
Telephone: ( )
Date: / /

My commission expires:

LORRAINE BOWER
Notary Public-Notary Seal
State of Missouri, St Louis County
Commission # 11057191
My Commission Expires Jun 6, 2015

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

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: MHDCHC	Position: ATTENDING	08/01/11	__/__/__ (Present)
Street: 5471 DR MLK DR	City: ST. LOUIS	State: MO	
Facility: BARNES JEWISH HOSPITAL	Position: VOLUNTARY ATTENDING	08/01/11	__/__/__ (Present)
Street: 1 BARNES PLAZA	City: ST. LOUIS	State: MO	
Facility: VACATION	Position:	07/01/11	07/31/11
Street:	City:	State:	
Facility: BARNES JEWISH HOSP	Position: FELLOW	07/01/09	06/30/11
Street: 1 BARNES JEWISH PLAZA	City: ST. LOUIS	State: MO	

1. List other states (abbreviations) where you are currently or have ever had a full license: MO ____ ____
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 completed the Opioid and Pain Management training (see Full Instructions, page?) ☐ Yes ☒ No
6. Reason for requesting a Massachusetts medical license: RELOCATION BACK HOME
7. Name of Facility: RIVERBEND MEDICAL GROUP
   Address: 1109 GRANBY City: CHICOPEE
8. Anticipated starting date in Massachusetts: 09/01/12
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.

_____ 4 / 17 / 12
Signature of Applicant Month Day Year

(Continued on page 5)

PRINT NAME: VILKEN, ZEVIDAH PAGE 4 OF 8

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: MIDCHC	Position: ATTENDING	08/01/11	/ / (Present)
Street: 5121 DELMAR DR	City: ST. LOUIS	State: MO	
Facility: BARNES JEWISH HOSPITAL	Position: HOSPITALIST	02/01/11	/ / (Present)
Street: 1 BARNES JEWISH PLAZA	City: ST. LOUIS	State: MO	
Facility: VACATION	Position:	07/01/11	07/31/11
Street:	City:	State:	
Facility: BARNES JEWISH HOSP	Position: FELLOW	07/01/09	06/30/11
Street: 1 BARNES JEWISH PLAZA	City: ST. LOUIS	State: MO	

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

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): CARDIOLOGY & GYNECOLOGY

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

6. Reason for requesting a Massachusetts medical license: RELOCATION BACK HOME

7. Name of Facility: RIVERBEND MEDICAL GROUP
   Address: 1109 GRANDE City: CHICOPEE

8. Anticipated starting date in Massachusetts: 09/01/12

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 of Applicant: _____ 9 / 17 / 12 (Month / Day / Year)

(Continued on page 5)

Application #: 3/26/15
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)

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

☒ 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.)
VICKERY	TERESA	LYNNE	

Date of Birth: ___ ___ ___ (Month Day Year) Security Number: ___ - ___

Place of Birth: CONCORD (City) MA (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: 5971 Dr. Mlk Dr. (Number and Street) Telephone: 314 361 5820

St. Louis (City) MO (State/Province/Territory) 63112 (Zip (or postal) Code)

E-mail Address: ___ Fax number: 314-361-8359

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 WA	Degree: —		09/01/99	12/01/01
Street: 025 SCHMITZ HALL, BOX 355550	City: SEATTLE	State: WA		
Facility: UNIVERSITY OF MA	Degree: BA		09/01/88	05/30/92
Street: 37 MATTHER DRIVE	City: AMHERST	State: MA		

Medical School

			From	To
Facility: BEN GURION UNIVERSITY	Degree: MD		09/24/01	5/31/05
Street: PO BOX 653	City: BEER SHEVA	State: ISRAEL		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 05 / 31 / 2005
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: BETH ISRAEL MED CTR	Position: PGY 1 INTERN		07/01/05	06/30/06
Street: 1ST AVE @ E 16TH ST	City: NEW YORK	State: NY		
Facility: BETH ISRAEL MED CTR	Position: PGY 2,3,4 RESIDENT		7/1/06	6/30/09
Street: 1ST AVE @ E 16TH ST	City: NEW YORK	State: NY		
Facility: WASHINGTON UNIVERSITY	Position: PGY 5, 6 FELLOW		07/01/09	06/30/11
Street: 660 S. EUCLID	City: ST. LOUIS	State: MO		
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, FLEX). 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	~~06/02~~ 08/2003	☒ P	☐ F	1
USMLE Step II	~~05/04~~ 11/04	☒ P	☐ F	2
USMLE Step III	08/07	☒ 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		☐ P	☐ F	

(State of examination)

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: MHDCHC Street: 5971 DR MLK DR	Position: ATTENDING City: ST. LOUIS	08/01/11 State: MO	/ / (Present)
Facility: BARNES JEWISH HOSPITAL Street: 1 BARNES PLAZA	Position: VOLUNTARY ATTENDING City: ST. LOUIS	08/01/11 State: MO	/ / (Present)
Facility: VACATION Street:	Position: City:	07/01/11 State:	07/31/11
Facility: BARNES JEWISH HOSP. Street: 1 BARNES JEWISH PLAZA	Position: FELLOW City: ST. LOUIS	07/01/09 State: MO	06/30/11

1. List other states (abbreviations) where you are currently or have ever had a full license: MO
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 completed the Opioid and Pain Management training (see Full Instructions, page?) ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: RELOCATION BACK HOME
7. Name of Facility: RIVERBEND MEDICAL GROUP
   Address: 1109 GRANBY City: CHICOPEE
8. Anticipated starting date in Massachusetts: 09/01/12
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.

_____ 4 / 17 / 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 4 3 7 3 0 9 6 4 8

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: 6 / 17 / 12

SUPPLEMENT FORM

PRINT NAME: VICKERY, ZEVIDAH DATE: 4/17/12

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 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: 4/17/12

	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 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?		
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:** 4 / 13 / 12

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

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) NO CLAIMS ON FILE.
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.** * 2005 ONLY

Liability Carrier: * HANYS Insurance Co, Inc From: 7/1/05 To: 12/05
City: White Plains State: NY Policy Number: 06-[illegible]-HP

Liability Carrier: Hospital Insurance (Luby) Inc From: 1/2006 To: 12/2006
City: White Plains State: NY Policy Number: 07-[illegible]-HP

Liability Carrier: Hospital Insurance (Luby) Inc From: 1/1/2007 To: 12/2007
City: White Plains State: NY Policy Number: 07-[illegible]-HP

2008: 08-[illegible]-HP

2009: 09-[illegible]-HP

Applicant's signature: [signature] Date: 02/27/12

Print Name: ZEVIDAH VICKERY

Address: City:

State: Zip code:

Additional forms available at the Board's website at www.mass.gov/massmedboard

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: HOSPITAL INSURANCE Co. Inc From: 7 / 05 To: 6 / 09
City: WHITE PLAINS State: NY Policy Number:

Liability Carrier: WASHINGTON D.C. From: 07 / 09 To: 06 / 11
City: ST. LOUIS State: MO Policy Number:

Liability Carrier: FTCA DEEMING NOTICE From: 08 / 11 To: 12 / 12
City: ST LOUIS State: MO Policy Number:

Applicant's signature: _____ 4 / 17 / 12 Date

Print Name: ZENDAH MCCLAY

Address: _____ City: _____

State: _____ Zip code: _____