REDACTED COPY

RECEIVED
Board of Registration in Medicine

Board of Registration in Medicine

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

FULL LICENSE APPLICATION

RECEIVED

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

Type of License: [X] Initial Full License [ ] Administrative License [ ] Volunteer License

Check One: [X] U.S. Canadian Graduate [ ] International Graduate

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

NIPPITA SIRIPANTH

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

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

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

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

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

NPI (National Provider Identifier) Number. 1265699375

Place of Birth: Bronxville New York
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: 622 West 168th Street, PH-16-76 Telephone: 212-305-4805
Number and Street

New York New York 10032
City State/Province Territory Zip (or postal) Code

E-mail Address: ______ Fax number: 212-305-6438

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

* The Board will use your Mailing Address for all correspondence

Revised 02.12.2013

Pre-medical School

		From	To
Name: Harvard College	Degree: AB	Year: 1996	Year 2000
Street: 1350 Massachusetts Avenue	City: Cambridge	State: MA	
Name: Harvard Extension School	Degree: none	Year: 2000	Year 2001
Street: 51 Brattle Street	City: Cambridge	State: MA	

Medical School

Name: Tufts University School of Medicine Degree: MD
Street: 145 Harrison Avenue City: Boston State: MA

Name: ____________________ Degree: ________
Street: ____________________ City: ____________ State: ________

Medical School Graduation Date: 5 / 20 / 2007
Month Day Year

Postgraduate Education:

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

			From	**To**
Facility: Columbia University Medical Center	PGY Year: 1-4		7/2007	6/2011
Specialty: Obstetrics/gynecology		City: New York	State: NY	
Facility: Columbia University Medical Center	PGY Year: 5-6		7/2011	7/2013
Specialty: Obstetrics/gynecology, Fellowship in Family Planning		City: New York	State: New York	
Facility:	PGY Year		/	/
Specialty:		City:	State:	
Facility:	PGY Year		/	/
Specialty:		City:	State:	
Facility:	PGY Year		/	/
Specialty:		City:	State:	

Examination History

Please contact the appropriate examination entity and have 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, COMVEX, COMLEX or a state examination. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

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

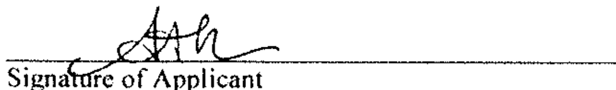
Hospital Affiliations and Employment

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

		From	To
Facility: New York Presbyterian / Columbia	Position: House staff	7 / 2007	6 / 2011
Street: 622 W. 168th Street, PH 16	City: New York	State: NY	
Facility: Columbia University	Position: Clinical Instructor	7 / 2011	6 / 2013
Street: 622 W. 168th Street, PH 16-69	City: New York	State: NY	
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 NY
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):
4. List your practice specialt(ies) obstetrics / gynecology (Board eligible)
5. Have you completed the Opioid and Pain Management training (see Full Instructions, page 3) ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Employment in a Massachusetts hospital
7. Name of Facility: Beth Israel Deaconness Medical Center
   Address: 330 Brookline Avenue City: Boston
8. Anticipated starting date in Massachusetts: 7 / 8 / 2013
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

3 / 26 / 13
Month Day Year

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, Siripanth Nippita
(type/print your complete name)

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

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

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

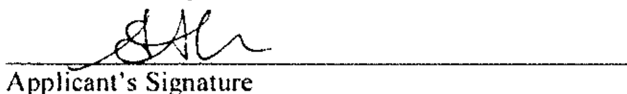
Attention: Licensing

Immunity and Release

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

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

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



Applicant's Signature

3/20/2013
Date of Signature

Nippita Siripanth
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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, Siripanth Nippita,
(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: ____________________ DATE: 3/26/2013

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: ____________________ DATE: 3/26/2013

Siripanth Nippita, MD

Professional Experience

***Family Planning Fellow & Clinical Instructor*, Columbia University** — New York, NY
Full tuition scholarship from Mailman School of Public Health. — *7/2011 – present*

***Residency in Obstetrics/Gynecology*, New York Presbyterian-Columbia** — New York, NY
International rotation at Chulalongkorn Hospital, Bangkok. — *7/2007 – 6/2011*

***Faculty Assistant*, Stanford University School of Medicine** — Stanford, CA
Provided administrative support to gynecology division chief. — *8/2002 –6/2003*

***Assistant Director*, Institute for Health and Social Justice, Partners In Health** — Boston, MA
Managed Institute fellowships and internships. Edited and researched manuscript on AIDS pandemic. Planned and coordinated annual symposium. — *9/2000 – 6/2002*

Education

Mailman School of Public Health, Columbia University — New York, NY
M.S. in Biostatistics, patient-oriented research track. — *7/2011 – present*

Tufts University School of Medicine — Boston, MA
M.D. *Clinical Honors* in ob/gyn, medicine, and pediatrics. — *8/2003 – 5/2007*

Harvard University — Cambridge, MA
A.B. *magna cum laude* in Social Studies. John Harvard Scholarship. — *9/1996 – 6/2000*
Certificate in Latin American Studies and Foreign Language Citation in Portuguese

Research

Castaño, P., S. Nippita, and C. Westhoff. *Ongoing.* "Quick Start Insertion of Mirena and ParaGard Intrauterine Devices." Family Planning Fellowship Research Project, Columbia University.

Nippita, S. 2011. "Stop Before You Pap: Cervical Cancer Screening Practices at Resident Continuity Clinic." Residency Research Project, Columbia University.

Nippita, S. 2000. "Between Sin and Survival: The Rift in Language and Discourse on Abortion in Public and Private Spheres in Brazil." Harvard University Honors Thesis.

Internships

Research Assistant, **Breast Cancer Risk Factor Study** — Boston, MA
Developed questionnaire and managed data collection. — *Summer 2004*

Intern, **Grupo Transas do Corpo** — Goiânia, Brazil
Researched access to abortion services in Brazil. — *Summer 1999*

Intern, **United Nations Children's Fund** — Pyongyang, Democratic People's Republic of Korea
Supported operations of child welfare site visits. — *Summer 1998*

Intern, **Ministry of Foreign Affairs** — Bangkok, Thailand
Drafted documents and resolutions promoting economic development. — *Summer 1997*

Languages

Bilingual in Thai and English, fluent in Portuguese and Spanish.

SUPPLEMENT FORM

PRINT NAME: Siripanth Nippita DATE: 3 /26 /2013

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?

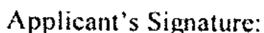
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?

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: Date: 3 / 26 / 13

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:______________ Date: 3 / 26 / 13

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).

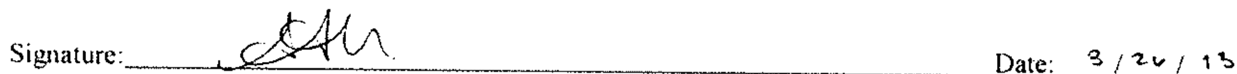
Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out 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.



Signature:________ Date: 3 / 26 / 13

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: [signature] Date of Birth

Print or Type Name: NIPPITA (Last name) SIRIPANTH (First Name) (Middle Initial) Social Security No:

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

Name of Medical School: TUFTS UNIVERSITY SCHOOL OF MEDICINE

Address: 195 HARRISON AVE City: BOSTON 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) to the applicant in a sealed envelope with the medical school seal affixed across the back of the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

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

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

Applicant's Undergraduate School: Harvard University

Undergraduate School Address: Cambridge, MA

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Nippita Siripanth

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	8/25/03	5/21/04	7/31/06	4/20/07
	8/16/04	5/13/05	/ /	/ /
	7/5/05	6/16/06	/ /	/ /

The applicant attended 148 total weeks *or* ______ total months (must be included) **of not less than 32 weeks in each academic year of continuing on-campus education.**

check one ☒ was awarded a degree in MD on (month/day/year) 5/20/07

☐ 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?		
5. Was the medical school education more than 4 years for U.S. graduates or more than 6 years for international graduates?		

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: Carol A. Duffey

Print Name: Carol A. Duffey

Title: Registrar

Date: 3/15/13 Telephone: (617) 636-6528

E-mail address: carol.duffey@tufts.edu

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the sealed envelope. Thank you

Seal Verified 4/11 CR

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: Date: 3 / 15 / 13

Print or type name: Siripanth Nippita

License number: 260010 Status of license: ☒ Active ☐ Inactive ☐ Other______

TO BE COMPLETED BY STATE BOARD

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

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

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

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

If "yes," please explain:______

Other derogatory information:______

Remarks:______

Signed:______

BOARD SEAL

Print Name:______

Title:______

State Board:______ Date: __/__/__

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

Board of Registration in Medicine
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Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 5/16/2013

Print or Type Name: Siripanth Nippita

Name of Institution: Columbia University

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 training was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Columbia University Medical Center, Dept OB/GYN

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

Enrollment and Participation: Our records indicate that Siripanth Nippita (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	AD 5/31/13 ~~5~~ 6	Family Planning	AD 5/31/13 ~~7/11~~ 7/1/2011	AD 5/31/13 ~~6/13~~ 6/30/2012	Yes	Not accredited
Fellowship	6	Family Planning	7/1/2012	6/30/2013	~~Yes~~ AD 6/11/13 No	Not accredited

(Continued on page 2)

Board of Registration in Medicine

APPLICANT'S NAME: Sirpath Nippita

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of this postgraduate training program.. 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 program ☐ was accredited by: ☐ ACGME ☐ Other:________

COMMENTS;__________

AFFIX INSTITUTIONAL SEAL HERE

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

Nurys Torres
Notary Public, State of New York
No. 01TO6191891
Qualified in Manhattan County
Commission Expires August 18, 2016

Nurys Torres

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

Program Director's Signature: ________ ☒ M.D. ☐ D.O.

Print Name: Anne Davis

Academic Title: Associate Professor of Clinical O/G

Telephone: (212) 305-4951 Today's Date: 05/20/13

E-mail address: ard4@columbia.edu

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

Seal Verified
DATE: 05/30/13
INITIALS: WS

RECEIVED
MAY 2 2 2013
Board of Registration in Medicine

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature [signature] Date 5/14/13

Print or Type Name Sniparth Nippita

Name of Institution Columbia University Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: [illegible]

If name of the institution was different when applicant attended, please enter name.

Enrollment and Participation: Our records indicate that [illegible] (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
			07/01/07	06/30/08		
Internship	1	OB/GYN	~~07/07~~	~~[illegible]~~	yes	ACGME
Residency	2-4	OB/GYN	~~07/[illegible]~~	~~[illegible]~~	yes	ACGME
			07/01/08	06/30/11		

(Continued on page 2)

APPLICANT'S NAME: Sripanth Nippita

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during <u>any part</u> of this postgraduate training program.. 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 issues?		

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

COMMENTS; ____________

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: [signature] ☒ M.D. ☐ D.O.

Print Name: Rini Ratan, MD

Academic Title: Residency Program Director

Telephone: (212) 305 2376 Today's Date: 03/14/2013

E-mail address: ____________

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

Seal Verified
D: 4/11
INITIALS: RM

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 5/15/2013

Print or Type Name: Siripanth Nippita

Name of Institution: Columbia University

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 training was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Columbia University Medical Center, Dept OB/GYN

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

Enrollment and Participation: Our records indicate that Siripanth Nippita (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 (AD 5/31/13)	Family Planning	~~7/11~~ 7/1/2011 (AD 5/31/13)	~~6/13~~ 6/30/2012 (AD 5/31/13)	Yes	Not accredited
Fellowship	6	Family Planning	7/1/2012	6/30/2013	~~Yes~~ No (AD 6/10/13)	Not accredited

(Continued on page 2)

Board of Registration in Medicine

APPLICANT'S NAME: Sirpath Nippita

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of this postgraduate training program.. 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 program ☐ was accredited by: ☐ ACGME ☐ Other:________

COMMENTS;________

AFFIX INSTITUTIONAL SEAL HERE

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

Nurys Torres
Notary Public, State of New York
No. 01TO6191591
Qualified in Manhattan County
Commission Expires August 18, 2016

Nurys Torres

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

Program Director's Signature: ________ ☒ M.D. ☐ D.O.

Print Name: Anne Davis

Academic Title: Associate Professor of Clinical O/G

Telephone: (212) 305-4951 Today's Date: 05/20/13

E-mail address: ard4@columbia.edu

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

Seal Verified
DATE: 05/30/13
INITIALS: WS

RECEIVED
MAY 2 2 2013
Board of Registration in Medicine

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature [signature] Date 5/14/13

Print or Type Name Suparna Nippita

Name of Institution Columbia University Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution [illegible]

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

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

(List each year separately with from and to dates)

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

(Continued on page 2)

APPLICANT'S NAME: Sripanth Nippita

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during <u>any part</u> of this postgraduate training program.. 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 issues?
6. During the applicant's participation, our postgraduate medical training program ☒ was accredited by: ☒ ACGME ☐ Other: ____

COMMENTS: ____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Rini Banerjee Ratan ☒ M.D. ☐ D.O.

Print Name: Rini Ratan, MD

Academic Title: Residency Program Director

Telephone: (212) 305 2376 Today's Date: 03/14/2013

E-mail address: ____

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

Seal Verified

D: 4/11

INITIALS: PM

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

Current Status: Active **License Expiration Date:** 9/20/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
330 Brookline Avenue, Shapiro 8th Floor
Boston
Massachusetts - 02215
United States of America

Home Address:

Business Address:
330 Brookline Avenue, Shapiro 8th Floor
Boston
Massachusetts - 02215
United States of America
(617) 667-3736

3) **Email Address:**

4) **Fax Number:** (617) 667-7493

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**
New York

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
Beth Israel Deaconess Medical Center	

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/06/2014	12/31/2014	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

22) **Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Profile and I will contact the Board for assistance with certain information.

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: Siripanth Nippita, M.D. **License No.:** 255545

Current Status: Active **License Expiration Date:** 9/20/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
330 Brookline Avenue, Shapiro 8th Floor
Boston
Massachusetts - 02215
United States of America

Home Address:

Business Address:
330 Brookline Avenue, Shapiro 8th Floor
Boston
Massachusetts - 02215
United States of America
(617) 667-3736

3) **Email Address:**

4) **Fax Number:** (617) 667-4173

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**
New York

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
Beth Israel Deaconess Medical Center	

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2016	12/31/2016	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

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?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital that has a CMS Meaningful Use program.

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Siripanth Nippita, M.D. **License No.:** 255545

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Profile and I will contact the Board for assistance with certain information.

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.**