

5/4/08
AM # 732

REDACTED COPY

Application #: 229113
Date Approved: / /

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 - www.massmedboard.org

RECEIVED
APR 28 2008
Board of Registration
in Medicine

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print or type your answers. Please attach a \$100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

- Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- Graduate of an International Medical School (IMG)
- Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) TANG (First) JENNIFER (MI) H

1-B. Other Name(s): _____

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|-------------------------------------|
| 1) Have you ever been known under a different name or combination of names? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2) Have you ever been licensed under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answer yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

3. Date of Birth: _____ Place of Birth: _____
(Month) (Day) (Year)

4. Sex: Male Female 5. Social Security Number: _____

6. Name of Massachusetts Training Hospital: Brigham and Women's Hospital
75 Francis Street Boston

(Street Address) (City)

PRINT NAME JENNIFER H TANG

Page 2 of 6

7. Name of premedical school(s): RICE UNIVERSITY

Location: HOUSTON, TX, USA
(City, State, Country)

8. Name of medical school(s): BAYLOR COLLEGE OF MEDICINE

Location: HOUSTON, TX, USA
(City, State, Country)

Date of Graduation: 05/23/06 Degree: M. D. D. O. Other(specify) _____
(Month) (Day) (Year)

9. Have you had previous post-graduate training? No Yes U.S. or International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you ever had a license to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or training license (L).

____ (Full) ____ (Full) ____ (Full) ____ (Limited) (Limited) ____

11. Please indicate all the licensing examinations that you have completed with a passing score:

USMLE Step 1 Step 2 Step 3 NBME Part I Part II Part III

FLEX Part I Part II COMLEX Level 1 Level 2 LMCC

YES NO

12-A. If you are a USMG, have you taken more than 4 years to complete medical school?

12-B. If you are an IMG, have you taken more than 6 years to complete medical school?
If yes, you must provide additional information. (See instructions).

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?
If yes, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

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PRINT NAME JENNIFER H TANG

06/29/06 02

02

7. Name of premedical school(s): RICE UNIVERSITY

Location: HOUSTON, TX, USA
(City, State, Country)

8. Name of medical school(s): BAYLOR COLLEGE OF MEDICINE

Location: HOUSTON, TX, USA
(City, State, Country)

Date of Graduation: 05 / 23 / 06 Degree: M. D. D. O. Other(specify) _____
(Month) (Day) (Year)

9. Have you had previous post-graduate training? No Yes U.S. or International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you ever had a license to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or training license (L).

_____ (Full) _____ (Full) _____ (Full) _____ (Limited) (Limited) _____

11. Please indicate all the licensing examinations that you have completed with a passing score:

USMLE Step 1 Step 2 Step 3 NBME Part I Part II Part III

FLEX Part 1 Part II COMLEX Level 1 Level 2 LMCC

YES NO

12-A. If you are a USMG, have you taken more than 4 years to complete medical school?

12-B. If you are an IMG, have you taken more than 6 years to complete medical school?
If yes, you must provide additional information. (See instructions).

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?
If yes, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT

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This certifies that Jennifer Tang has been appointed
(Name of Applicant)

to the position of Intern Resident Fellow

in the specialty of OB-GYN as a PGY 1

Department: OB-GYN Subspecialty: _____

at BRIGHAM AND WOMENS HOSPITAL
(Name of Healthcare Facility)

beginning 6/20/06 to anticipated completion of training: 6/30/07
(Month) (Day) (Year) (Month) (Day) (Year)

- | | <u>YES</u> | <u>NO</u> |
|---|-------------------------------------|--------------------------|
| 1. Is the program accredited by the ACGME? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. If no, is there an ACGME-approved training program in the applicant's specialty? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you reviewed Sections A and C of the limited license application? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Designated Official's Signature: Jill Bradshaw

Type or Print Name: Jill Bradshaw

Official Title: LICENSE COORDINATOR

Date: 4/26/06 Telephone Number: 5821193

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

PRINT NAME: JENNIFER H. TANG

Page 4 of 6

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.

YES NO

14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).

If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.

15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?

- 16-A. Have you ever been terminated by a medical school or postgraduate training program?

- 16-B. Have you ever been granted a leave of absence by a medical school or a postgraduate training program?

- 16-C. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?

If you answered "yes" to 16-A, B or C, a letter from your medical school(s) or postgraduate training program(s) is required.

17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

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

19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

PRINT NAME: JENNIFER H. TANG

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YES NO

20. 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).
21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).
22. 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?
23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you ever voluntarily relinquished medical staff membership?
25. 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?
26. Have you ever been charged with any criminal offense, other than a minor traffic offense?
27. 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?
28. 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?
29. 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?

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PRINT NAME: JENNIFER H. TANG

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CONFIDENTIAL MEDICAL 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 Limited License Supplement. 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.

YES NO

- 30. 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?
- 31. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
- 32. 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 limited or impaired?
- 33. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
- 34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?
- 35. Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

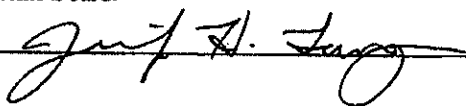
If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

CERTIFICATIONS:

- 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 and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (Note: This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Applicant's Signature:  Date: 03/17/06



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 (617) 654-9810

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

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I, JENNIFER HUI-YU TANG
(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
560 Harrison Avenue, Boston, MA 02118
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.

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.

[Handwritten Signature]
Applicant's Signature

03/17/06
Date of Signature

TANG, JENNIFER, H
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

JENNIFER H. TANG

EDUCATION

- M.D. Baylor College of Medicine, 2006 (expected). Houston, TX.
Certification in International Health, 2006 (expected).
Women's Health Track, 2003-2004.
- B.A. Rice University, 2001. Houston, TX. Major: Asian Studies. GPA: 3.7/4.0.
School for International Training, 1999. Yunnan, China. GPA: 4.0/4.0.

RESEARCH EXPERIENCE

Doris Duke Clinical Research Fellow, Department of Obstetrics and Gynecology, University of Texas Southwestern, 2004-2005. Dallas, TX.

Worked on various research projects within the Division of Infectious Disease and the Division of Family Planning, including:

- 1) Data collection and writing of a paper (to be submitted) to determine the effect of protease inhibitor therapy on glucose intolerance in pregnancy. Project Mentor: Jeanne S. Sheffield, M.D.
- 2) Database management and enrollment of patients into a study evaluating the feasibility and efficacy of hepatitis B vaccination of high-risk women during prenatal care. Principal Investigator: Jeanne S. Sheffield, M.D.
- 3) Data collection and writing of a paper (to be submitted) concerning the rate of cholecystectomy in Mexican-American women initiating oral contraceptive use postpartum. Principal Investigator: Gretchen S. Stuart, M.D., MPH/TM.
- 4) Data analysis of a pilot study in teenagers comparing the oral contraceptive pill versus the patch. Principal Investigator: Gretchen S. Stuart, M.D., MPH/TM.
- 5) Data collection to determine the effect of neurocysticercosis on pregnancy. Principal Investigator: F. Gary Cunningham, M.D.

Independent Clinical Research, Children's Nutrition Research Center, Department of Pediatrics, Baylor College of Medicine, 2003. Houston, TX.

Project Mentor: Steven A. Abrams, M.D.

Traveled with Nutrition Team to evaluate macronutrient and micronutrient deficiencies in rural Panama. Also analyzed growth parameters from a cohort of children in Santa Ana, Honduras to develop an effective nutritional supplement program.

Independent Study Project, School for International Training, 1999. Yunnan, China.

Project Mentor: Lu Yuan, M.A.

Thesis: "Healthcare Issues in Yunnan, China: Disparities in Quality and Access and China's Health Transition from Infectious to Chronic Disease."

Interviewed administrators and health professionals from hospitals and disease prevention centers to determine progress made in Yunnan province since the publication of the 1990 World Health Organization Country Report on China.

Independent Undergraduate Research, Department of Biochemistry and Cell Biology, Rice University, 1998-1999. Houston, TX.

Principal Investigator: Susan I. Gibson, Ph.D.

Performed lab research to identify and characterize plant beta-amylase activity to determine its role in starch biosynthesis and improve plant starch quality and quantity.

POSTER PRESENTATIONS

- 1) Stuart GS, Tang JH, Westhoff CL, and the Quickstart Study Group. An increased rate of cholecystectomy in a cohort of women initiating oral contraceptive pills. September 2005 (to be presented). 42nd Annual Meeting of the Association of Reproductive Health Professionals.
- 2) Tang JH, Wendel Jr GD, Sheffield JS. Hepatitis B vaccination of high-risk pregnant women. June 2005. 4th Annual Doris Duke Clinical Research Fellow Meeting.
- 3) Tang JH, Stuart GS, Langston A, Moses BZ, Heartwell SF A pilot study in teenagers – the oral contraceptive pill versus the patch. May 2005. 53rd Annual Clinical Meeting for the American College of Obstetrics and Gynecology.
- 4) Tang JH, Wendel Jr GD, Sheffield JS. Hepatitis B vaccination of high-risk pregnant women. January 2005. 43rd Annual Medical Student Research Forum at the University of Texas Southwestern.

WORK EXPERIENCE

Michael E. DeBakey Summer Surgery Program, Baylor College of Medicine: Summer Intern, 2000.
 Jones Graduate School of Business (Rice University): Research Assistant, 1999-2000.
 Baylor College of Medicine, Department of Pathology: Summer Intern, 1999.

HONORS/AWARDS*Medical School*

Alpha Omega Alpha, nominated August 2005
 Doris Duke Clinical Research Fellowship at the University of Texas Southwestern, 2004-2005.
Awarded the "Basic Certificate of Training in Patient-Oriented Research."
 "Chapter Project of the Month" Award for an American Medical Association Policy
 Promotion Grant establishing an "International Health Week," 2002.
 Rice/Baylor Medical Scholars Program (combined eight-year B.A./M.D. program).

Undergraduate

Outstanding Senior Award, presented by the Rice University Student Association, 2001.
 Who's Who in American Colleges & Universities, 2001.
 Golden Key National Honor Society, 2001.
 Anderson Consulting Award in Managerial Studies, 2000.
 Duke Energy Study Abroad Grant, Institute of International Education, 1999.
 Houston Junior Council of Commerce Study Abroad Scholarship, 1999.

ACTIVITIES/PROFESSIONAL ORGANIZATIONS

Baylor American Medical Women's Association: Executive Board, 2005-2006.
 Baylor Obstetrics and Gynecology Student Interest Group: Executive Board, 2005-2006.
 Global Health Education Consortium: Annual Meeting Delegate, 2004.
 Baylor World Health Student Organization: Co-Chair & Nutrition Committee Chair, 2003-2004.
 Baylor Shoulder-to-Shoulder Foundation Honduras: Volunteer & Public Relations Chair, 2002-2004.
 International Federation of Medical Students' Associations: Annual Meeting Delegate, 2003.
 Baylor American Medical Association/Texas Medical Association: Internal Vice President, 2001-02.
 American Medical Student Association: Annual Meeting Participant, 2002.
 Baylor Asian Pacific American Medical Student Association: Service Chair, 2001-2002.

LANGUAGES

Spanish, basic reading and conversation.
 Mandarin Chinese, basic reading and intermediate conversation.

INTERESTS

Dancing, jogging/exercise, hiking, reading, piano, independent and foreign films,
 women's health education and advocacy, international work and travel, attending cultural events.

RECEIVED

LIMITED LICENSE APPLICANT

MAR 17 2006

COMMONWEALTH OF MASSACHUSETTS, BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 - (617) 654-9810 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

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: TAND JEANNEER Social Security No.: _____
(Last name) (First Name) (Middle Initial)

Other Name(s) _____

Name of Medical School: BAYLOR COLLEGE OF MEDICINE

Address: ONE BAYLOR PLAZA City: HOUSTON State or Province: TX

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. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

Premedical Education: Does your school have a premedical school education requirement? Yes No
If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Rice U (Tx)

Undergraduate School Address: Houston, Texas

LIMITED LICENSE APPLICANT

Tang Jennifer Hui-YU

(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
	08 / 06 / 2001	07 / 03 / 2002	07 / 06 / 2004	06 / 27 / 2005
	08 / 04 / 2002	06 / 21 / 2003	06 / 27 / 2005	05 / 23 / 2006
	07 / 07 / 2003	06 / 19 / 2004		

The applicant attended 133+ weeks courses & lectures total months of continuing on-campus education, not less than 32 weeks in each academic year

check one [x] was awarded a degree in Doctor of Medicine on (month/day/year) 05 / 23 / 2006 Expected Graduation Date [x] will be awarded on 05 / 23 / 2006 [] was NOT awarded degree. Please explain in comments section.

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.

1. Did the applicant take any leaves of absence or breaks from his/her medical education? YES NO
2. Was the applicant ever placed on probation? YES NO
3. Was the applicant ever disciplined or under investigation? YES NO
4. Were any negative reports ever filed by instructors regarding the applicant? YES NO

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: Lisa Chebret Print Name: Lisa Chebret Registrar Title: Date: 3 / 17 / 2006 Telephone: (713) 798-7766

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

WG 1/29/09

Check #: 000 3203391

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

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Renewal fee is \$100.00. Please read the attached instructions before completing application.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

- Name: (Last) Tang (First) Jennifer (MI) H
- Mailing Address: _____ Telephone #: _____
City: _____ State: _____ Zip: _____
- Name of Training Hospital: Brigham and Women's Hospital / Massachusetts General Hospital
- Current Limited License Number: 229113
- Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license or training license (limited).
 Full Full Limited Limited

SECTION B: To be completed by the program director.

Is the above named physician in good standing in the training program?

Has the physician been subject to past or pending disciplinary action in this program?

Print Name: Natasha Johnson MD Date: 1/20/2009

Signature of Program Director: [Signature] Telephone: 617-732-7801

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that Jennifer Tang has been appointed as an Intern Resident Fellow
(Name of Applicant)

Department of OB/Gyn Subspecialty _____

and as a PGY 4 or Fellowship year: _____ Academic Year: From: 7/1/09 To: 6/30/10

Is the program accredited by the ACGME: Yes No
If no, is there an approved ACGME program in applicant's specialty? Yes No

Designated Official: Dyeha Johnson Date: 1/22/09
(Print Name)

Designated Official's Signature: [Signature] Telephone #: 617-713-2284

Designated Official's Title: License Coordinator

JAN 20 2009
Board of Registration
in Medicine

NAME:

Jennifer Tang

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SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

YES NO

- 16-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
- 16-B. Have you, for any reason, been placed on probation in any postgraduate training program?
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
19. Have you voluntarily surrendered a license to practice medicine or any healing art?
20. 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).
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
22. Have you 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?
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you voluntarily relinquished medical staff membership?
25. 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?
26. Have you been charged with any criminal offense, other than a minor traffic offense?
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
29. 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?

(Continued on page 3)

NAME:

Jennifer Tang

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CONFIDENTIAL MEDICAL 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 Limited License Supplement. 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.

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEW

YES NO

30. 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?
31. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
32. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
33. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?
35. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

If your responses to Questions 16-35 change while your application is pending, you must notify the Board of the new information immediately.

(Continued on page 4)

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01/20/2008 09:21

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CERTIFICATIONS

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

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

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

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

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

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

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

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

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 limited licensure in Massachusetts.

Under the penalties of perjury, I declare that I have examined this limited renewal 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 renewal of a limited 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: _____

Date: 1/13/09

Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

1. Jennifer Hui-Yu Tang
(type/print your complete name)

I 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 Telephone: (781) 876-8210 Fax: (781) 876-8383
www.massmedboard.org 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.

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 JENNIFER HUI-YU TANG Date of Signature 1/23/09

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

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

01/23/09 12

DW
2/1/07
#115

License Number: 229113

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 - www.massmedboard.org

02/05/07 51

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Renewal fee is \$100.00. Please read the attached instructions before completing application.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

JAN 31 2007

SECTION A:

Board of Registration
in Medicine
(MI)

- 1. Name: (Last) Tang (First) Jennifer
- 2. Mailing Address: _____ Telephone # _____
City: _____ State: _____ Zip: _____
- 3. Name of Training Hospital: Brigham + Women's Hospital
- 4. Current Limited License Number: 229113
- 5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license or training license (limited).
 Full Full Limited Limited

SECTION B: To be completed by the program director.

Is the above named physician in good standing in the training program?
 Has the physician been subject to past or pending disciplinary action in this program?
 Print Name: Lori R. Berkowitz, MD Date: 1/19/07
 Signature of Program Director: [Signature] Telephone: 617-732-7801

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that Jennifer Tang has been appointed as an Intern Resident Fellow
(Name of Applicant)
 Department of Obstetrics + Gynecology Subspecialty _____
 and as a PGY 2 Beginning Date: 7/1/07 Anticipated End Date of training: 6/30/2008

Is the program accredited by the ACGME: Yes No
 If no, is there an approved ACGME program in applicant's specialty? Yes No

Designated Official: Jill Bradshaw CredCoord Date: 1/29/08
(Print Name) (Title)
 Designated Official's Signature: [Signature] Telephone #: 5821193

NAME: Jennifer Jang

Page 2 of 4

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

YES NO

02/05/07 51 104

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?
19. Have you voluntarily surrendered a license to practice medicine or any healing art?
20. 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).
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
22. Have you 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?
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you voluntarily relinquished medical staff membership?
25. 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?
26. Have you been charged with any criminal offense, other than a minor traffic offense?
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
29. 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?

(Continued on page 3)

NAME:

Jennifer Jang

Page 3 of 4

02-08-07 51 106

CONFIDENTIAL MEDICAL 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 Limited License Supplement. 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.

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEW

YES NO

- 30. 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?
- 31. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
- 32. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
- 33. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
- 34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?
- 35. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

If your responses to Questions 16-35 change while your application is pending, you must notify the Board of the new information immediately.

(Continued on page 4).

02-07-07 15:10

CERTIFICATIONS

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

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

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

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

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

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Signature: _____



Date: _____

12/07

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COMMONWEALTH OF MASSACHUSETTS—BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 (617) 654-9810

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Jennifer Tang
(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.

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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.

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.

Jennifer Tang
Applicant's Signature

11/20/07
Date of Signature

TANG, JENNIFER, H
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

02/06/07 51 107

WG 3/7/08
CNC 3/10/08
02/11/08 53

Check #: 144

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 - www.massmedboard.org

RENEWAL APPLICATION - LIMITED LICENSE

RECEIVED
FEB 26 2008
Board of Registration
in Medicine

IMPORTANT: Renewal fee is \$100.00. Please read the attached instructions before completing application.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

- Name: (Last) Tang (First) Jennifer (MI) _____
- Mailing Address: _____ Telephone #: _____
City: _____ State: _____ Zip: _____
- Name of Training Hospital: Brigham & Women's
- Current Limited License Number: 229113
- Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license or training license (limited).
 Full Full Limited Limited

SECTION B: To be completed by the program director.

Is the above named physician in good standing in the training program?
 Has the physician been subject to past or pending disciplinary action in this program?
 Print Name: Natasha R Johnson MD Date: 2/13/08
 Signature of Program Director: [Signature] Telephone: _____

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that Jennifer Tang (Name of Applicant) has been appointed as an Intern Resident Fellow
 Department of OB/GYN Subspecialty _____
 and as a PGY 3 or Fellowship year: _____ Academic Year: From: 7/1/08 To: 6/30/09
 Is the program accredited by the ACGME? Yes No
 If no, is there an approved ACGME program in applicant's specialty? Yes No
 Designated Official: Joanna Hazell (Print Name) Manager (Title) Date: 2/19/08
 Designated Official's Signature: [Signature] Telephone #: 617-582-1192

NAME: Jennifer Hui-Yu Tang

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

YES NO

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(Continued on page 3)

NAME: Jennifer Hui-Yu Tang

Jennifer H. Tang

03/11/08 SS

177

CONFIDENTIAL MEDICAL INFORMATION

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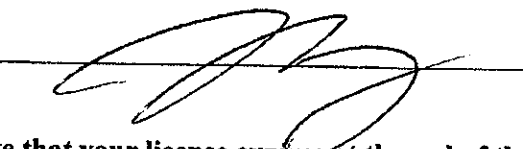
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Date: _____

1/31/08

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Limited License



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 (617) 654-9810

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1. Jennifer Hai-Yu Tang
(type/print your complete name)

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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.

[Signature]
Applicant's Signature

1/31/08
Date of Signature

Tang, Jennifer, H.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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