Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that LISA HOFLER
(Student's Name)

has completed the requirements for the ☒ M.D. degree ☐ D.O. degree

from Emory University School of Medicine
(Name of Medical School)

and will receive the degree on 05/10/2010.

Signature of Certifying Official: Huaye Dong
(Original Signature is required – Stamps not accepted)

Printed Name: Huaye Dong

Title: Academic Services Coordinator

Date: 04/01/2010

Please return the completed Form B to the Limited License Coordinator, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - Telephone: (781) 876-8210 Fax: (781) 876-8383. Thank you

RECEIVED
APR 16 2010
Board of Registration in Medicine

244368
Application #: _____

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

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly 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)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) HOFLER (First) LISA (MI) G

1-B. Other Name(s): LISA HOFLER BAXLEY (JULY 4, 2004 - MARCH 25, 2005)

	YES	NO
1) Have you ever been known under a different name or combination of names?	☒	☐
2) Have you ever been licensed under a different name?	☐	☒
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☒

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

2. Current Address: _____ Telephone Number: _____
City: _____ State: _____ Zip: _____

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

E-mail Address _____

4. Sex: ☐ Male ☒ Female 5. Social Security Number: _ ___ ____ ____

6. Name of Massachusetts Training Program: Obstetrics and Gynecology

330 Brookline Ave, KS-317 Boston, MA 02215
Street Address (City)

01/20/2010 09:02

PRINT NAME LISA HOFLER

7. Name of premedical school(s): GEORGIA INSTITUTE OF TECHNOLOGY
Location: ATLANTA, GA USA
(City, State, Country)

8. Name of medical school(s): EMORY UNIVERSITY SCHOOL OF MEDICINE
Location: ATLANTA, GA USA
(City, State, Country)

Date of Graduation: 05 / 10 / 2010 Degree: ☒ M. D. ☐ D. O. Other (specify)_____
(Month) (Day) (Year)

(See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? ☒ No ☐ Yes
Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____

Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____
(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). NONE
_____ ☐(Full) _____ ☐ (Full) _____☐ (Full) _____☐(Limited) _____ ☐ (Limited)

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

USMLE ☒ Step 1 ☒ Step 2 (CK) ☒ Step 2 (CS) ☐ Step 3

NBME ☐ Part I ☐ Part II ☐ Part III ☐ 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 with your curriculum vitae and include 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 TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT

This certifies that LISA HOFLER has been appointed
(Name of Applicant)

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the specialty of Obstetrics and Gynecology as a PGY 1

Department: Obstetrics and Gynecology Subspeciality: _____

at Beth Israel Deaconess Medical Center
(Name of Healthcare Facility)

beginning 06 / 21 / 2010 to anticipated completion of training: 06 / 30 / 2014
(Month) (Day) (Year) (Month) (Day) (Year)

	YES	NO
1. Is the program accredited by the ACGME?	☒	☐
2. If **no**, is there an ACGME-approved training program in the applicant's specialty ?	☐	☐
3. Have you reviewed Sections A and C of the limited license application?	☒	☐

Designated Official's Signature: Susan Herlihy Kilbride

Type or Print Name: Susan Herlihy Kilbride

Official Title: Administrative Director, GME

Date: 4 / 13 / 10 Telephone Number: 617-667-9501

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

PRINT NAME: LISA HOFLER

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. You must answer all questions or your application will be returned to you.

	YES	NO
14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training?		
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 or granted a leave of absence, regardless of the reason, by a medical school or any postgraduate training program?		
16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or any postgraduate training program?		
16-C. Have you ever, for any reason, been placed on probation in medical school or any postgraduate training program?		
If you answered "yes" to 16-A, B or C, you must provide an explanation and request a letter of explanation from your medical school or postgraduate training program.		
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?		

		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 any medical staff membership, medical staff privileges or medical staff status?		
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?		

PRINT NAME: LISA HOFLER

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 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.
- Under the penalties of perjury, I declare that I have examined this limited license 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 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.

Applicant's Signature Lisa Hofler **Date:** 03 / 26 / 2010

Revised: 8.12.08

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

I, LISA GAY HOFLER
(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 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.

Lisa Hofler
Applicant's Signature

03/26/2010
Date of Signature

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

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

Harvard Medical School
Curriculum Vitae

Date Prepared: April 7, 2010

Name: Lisa Hofler

Office Address: 300 Brookline Ave, KS 317 Boston, MA 02215

Home Address:

Work Phone: 617-667-2285

Work E-Mail:

Work FAX: 617-667-4173

Place of Birth:

Education

8/00-5/04	BS, Highest Honor	Chemical Engineering	Georgia Institute of Technology
07/04-05/05	MD, MPH	Medicine/Epidemiology	Emory University
07/06-05/10	anticipated May 10, 2010		

Postdoctoral Training

06/10-	Resident anticipated June 21, 2010	Obstetrics and Gynecology	BI Deaconess Medical Center

Other Professional Positions

06/05-12/05	Secretary	Oxford Building Solutions	Oxford, UK
01/06-06/06	Secretary	Carter Jonas, LLP	Oxford, UK

Professional Societies

2004-2010		Medical Students for Choice
	2006-2007	School Coordinator, Emory University
	2007-2010	Student Advisory Council
	2007-2008	Member, Leadership Recruitment Committee
	2007-2008	Member, Leadership Training Committee
	2008-2010	Chair, Leadership Recruitment Committee
	2007-2008	Regional Coordinator, Region 10
	2008-2010	Board of Directors
	2008-2009	Member, Finance Committee
	2009-2010	Member, Executive Committee
	2008-2010	National Coordinator, Southeast
2004-2010		American Medical Students Association
2007-		Physicians for Reproductive Choice and Health
2007-		Association of Reproductive Health Professionals
2009-		American College of Obstetricians and Gynecologists

Honors and Prizes

2000-2004	President's Scholarship	Georgia Tech	Academic Achievement
2003	President's Undergraduate Research Award	Georgia Tech	Research
2006-2009	Leadership Training Program	Medical Students for Choice	

Report of Funded and Unfunded Projects

Current Unfunded Projects

2009-2010 Co-Investigator
Gender Differences in Kaposi Sarcoma in the United States: SEER Analysis 1973-2006
Exploring differences in demographics and survival between women and men diagnosed with Kaposi sarcoma in the United States from 1973-2006

Report of Local Teaching and Training

Teaching of Students in Courses

Georgia Institute of Technology

2002	PSYC1000 Intro to College Life Undergraduate students	Teaching Assistant Once-weekly lectures, all grading
2002	MATH1501 Calculus I Undergraduate students	Teaching Assistant Twice-weekly recitation sections, all grading
2003	MATH1712 Survey of Calculus Undergraduate students	Teaching Assistant Twice-weekly recitation sections, all grading
2003-2004	MATH1711 Finite Mathematics Undergraduate students	Teaching Assistant Twice-weekly recitation sections, all grading

Report of Clinical Activities and Innovations

Current Licensure and Certification

2010	Massachusetts Limited Medical License (application in process)

Report of Education of Patients and Service to the Community

Activities

2006-2007	Feminist Women's Health Center / Shadowing Program Coordinator Founded shadowing program, coordinated medical student shadowing experiences
2007	Open Door Clinic / Clinical Volunteer Participated in free outpatient clinic for homeless patients in Atlanta, GA
2007-2010	Health Students Taking Action Together (HealthSTAT) / Student Advocate Educated Georgia Legislators about public health implications of legislation; participated in 2007-2008 Save Grady Hospital Campaign
2009-2010	Good Samaritan Clinic / Clinical Volunteer Participated in free outpatient clinic for low-income patients in Atlanta, GA
2010	ICAmigos Clinica Medica Social / Clinical Volunteer Participated in free outpatient clinic for low-income and indigenous patients in Quetzaltenango, Guatemala

Recognition

2008	Named one of "30 Under 30"	Georgia Tech Alumni Magazine

Report of Scholarship

Publications

Professional Educational Materials or Reports, in print or other media

Medical Students for Choice Student Advisory Council Handbook
Wrote and compiled 90-page introductory, resource and reference guide used for incoming Student Advisory Council medical student members from across the US and Canada

Narrative Report

Medical education and reproductive health have always been extremely important to me, and during my years in medical school I became heavily involved in Medical Students for Choice, first as a School Coordinator and then as Regional Coordinator and National Coordinator for the Southeast United States. I also served on the Board of Directors and Student Advisory Council for Medical Students for Choice. In these roles I have helped organize six Regional Meetings in the Southeast and assisted with three Annual Meetings, and I have worked with medical students from Texas to Virginia to enhance medical education regarding women's reproductive health through curriculum changes and supplemental lectures.

My interest in public health led me to supplement my clinical medical education with a Master's of Public Health. My thesis project addresses the differences in survival between men and women diagnosed with Kaposi sarcoma in the United States. Because of my interest in indigent care I have volunteered at a number of medical clinics in the United States and Guatemala. In addition, I have been involved in patient and student advocacy with the Georgia legislature.

In the future I am interested in enhancing my involvement in medical education through increased clinical and teaching responsibilities as well as expanding my research to include preventive health topics in obstetrics and gynecology. With interests in caring for the underserved both in the United States and globally I hope to have an impact on communities through continued clinical service as well as through patient advocacy.

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

MEDICAL EDUCATION VERIFICATION – FORM A

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. **Please Note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

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: Lisa Hofer Date of Birth

Print or Type Name: HOFER (Last name) LISA (First Name) G (Middle Initial) Social Security No:

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

Name of Medical School: EMORY UNIVERSITY SCHOOL OF MEDICINE

Address: 1698 PIERCE DRIVE City: ATLANTA State or Province: GA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. 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: Georgia Institute of Technology

Undergraduate School Address: 765 Ferst Drive NE, Atlanta, GA 30318

Continued on page 2

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	Hofler (Last name)	Lisa (First name)	G. (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
	07/21/2004	05/16/2005	05/18/2009	05/10/2010
	07/19/2006	05/14/2007	/ /	/ /
	07/24/2007	05/12/2008	/ /	/ /

The applicant attended 168 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one ☐ was awarded a degree in _____ on (month/day/year) ___/___/___

☒ will be awarded on 05/10/2010 **(Form B must also be completed and returned directly to the Board)**

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? (Explain "personal leaves".)		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Huaye Dong

Print Name: Huaye Dong

Title: Academic Services Coordinator

Date: 04/01/2010 Telephone: (804) 727-0018

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

Commonwealth of Massachusetts

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications and information from health care entities.

***"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named* below:"**

(type or print clearly)

SEND LICENSE VERIFICATION TO: GEORGIA COMPOSITE MEDICAL BOARD

ADDRESS: 2 PEACHTREE ST, NW, 36TH FLOOR

CITY: ATLANTA STATE: GA ZIP: 30303

(TYPE OR PRINT)
PHYSICIAN'S NAME: LISA HOFLER

BUSINESS ADDRESS: 330 BROOKLINE AVE, KS-3

CITY: BOSTON STATE: MA ZIP: 02215

MASSACHUSETTS LICENSE NUMBER: 249368

SIGNATURE OF PHYSICIAN: L Hofler

Signed under the penalties of perjury

DATE: 11/22/2013

This Release shall remain valid for one (1) year from the date of execution

RECEIVED
NOV 25 2013
Board of Registration in Medicine

Date Received: 11/25/13
Check #: 1357
Check Amount: $ 10.00
Initials: CS

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application, or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications, and information from health care entities.

***"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named* below:"**

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: NEW MEXICO MEDICAL BOARD

ADDRESS: 2055 S. PACHECO STREET, BLDG 400

CITY: SANTA FE STATE: NM ZIP: 87505

PHYSICIAN'S NAME: LISA HOFLER

BUSINESS ADDRESS: 49 JESSE HILL JR DRIVE SE, ATLANTA, GA 30303 (CURRENT)
330 BROOKLINE AVE, KS-3, BOSTON, MA 02215 (FORMER/RESIDENCY)

CITY: STATE: ZIP:

MASSACHUSETTS LICENSE NUMBER: 244368

SIGNATURE OF PHYSICIAN: L Hofler 1/29/16

Signed under the penalties of perjury

DATE: 01/21/2016

Date Received: 1/29/16
Check #: 175
Check Amount: 10.00
Initials: LS

This release shall remain valid for one (1) year from the date of execution.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-317
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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? ____

Name: _____ **Date:** _____
Designation: _____ **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 _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

Designated Official's Name: _____ **Date:** _____
Designated Official's Title: _____ **Telephone:** _____

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

[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 Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-317
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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?

Name: Susan Herlihy Kilbride **Date:** 2/7/2011
Designation: Medical Education Manager, OBC **Telephone:** (617) 667-2966

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

This certifies that **Lisa G Hofler** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Lynnette Cheseborough **Date:** 2/9/2011
Designated Official's Title: GME Coordinator **Telephone:** (617) 667-3210

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

[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 Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-317
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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? ____

Name: _____ **Date:** _____
Designation: _____ **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 _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

Designated Official's Name: _____ **Date:** _____
Designated Official's Title: _____ **Telephone:** _____

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

[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 Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-317
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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?

Name: Martina DiNapoli **Date:** 1/24/2012
Designation: Residency Coordinator **Telephone:** (617) 667-2285

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

This certifies that **Lisa G Hofler** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Lynnette Cheseborough **Date:** 1/24/2012
Designated Official's Title: GME Coordinator **Telephone:** (617) 667-3210

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

☒ **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.**

☒ **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 Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-3
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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? ____

Name: _____ **Date:** _____
Designation: _____ **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 _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

Designated Official's Name: _____ **Date:** _____
Designated Official's Title: _____ **Telephone:** _____

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

[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 Limited Renewal Application

Physician Name: Lisa G Hofler, M.D. **License No.:** 244368

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Ave, KS-3
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 244368

5. **Other states where you are now licensed to practice medicine**
   None Reported

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?

Name: Lynnette Cheseborough **Date:** 2/14/2013
Designation: GME Coordinator **Telephone:** (617) 667-3210

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

This certifies that **Lisa G Hofler** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Lynnette Cheseborough **Date:** 2/14/2013
Designated Official's Title: GME Coordinator **Telephone:** (617) 667-3210

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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?

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

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

10. 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).

11. 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).

12. 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?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. 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?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

17. 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?

18. 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?

19. 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?

20. 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?

21. 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?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

1. 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.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

11. 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.

☒ **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.**

☒ **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.**