

258634

RECEIVED
MAR - 3 2014
Board of Registration
in Medicine

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

FULL LICENSE APPLICATION REDACTED COPY

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

Type of License Initial Full License Administrative License Volunteer License
Check One: U.S./Canadian Graduate International Graduate

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

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

M.D. D.O. PhD Other degree _____ Male Female

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

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

Social Security Number: _____ / _____ / _____ Date of Birth: _____
Month Day Year

NPI (National Provider Identifier) Number: 1063726933

Place of Birth: WORCESTER MA
City State/Province/Territory Country if not USA

* (until June 21, 2014) *
* Mailing Address: 5170 Clairemont Mesa Blvd Unit 11 Telephone: 508 826 1884
San Diego CA 92117
City State/Province/Territory Zip (or postal) Code

(permanent address)
Home Address: _____ Telephone: _____
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: 1620 Tremont Street, 4th floor Telephone: 508 826-1884
Number and Street

Boston MA 02110
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: until June 21st: 619 543 3703

Are you applying for licensure through FCVS? Yes No

* The Board will use your Mailing Address for all correspondence

Pre-medical School

From To

Name: Massachusetts Institute of Technology Degree: BS Year: 2002 Year 2006
 Street: 77 Massachusetts Ave City: Cambridge State: MA

Name: _____ Degree: _____ Year: _____ Year _____
 Street: _____ City: _____ State: _____

Medical School

Name: University of Hawaii - John A. Burns School of Medicine Degree: MD
 Street: 651 Ilalo Street City: Honolulu State: HI

Name: _____ Degree: _____
 Street: _____ City: _____ State: _____

Medical School Graduation Date: 05 / 15 / 2010
 Month Day Year

Postgraduate Education:

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

	From	To
Facility: <u>University of California - San Diego</u> PGY Year: <u>1</u>	<u>07 / 2010</u>	<u>06 / 2011</u>
Specialty: <u>Obstetrics & Gynecology</u> City: <u>San Diego</u> State: <u>CA</u>		
Facility: <u>University of California - San Diego</u> PGY Year: <u>2</u>	<u>07 / 2011</u>	<u>06 / 2012</u>
Specialty: <u>Obstetrics & Gynecology</u> City: <u>San Diego</u> State: <u>CA</u>		
Facility: <u>University of California - San Diego</u> PGY Year <u>3</u>	<u>07 / 2012</u>	<u>06 / 2013</u>
Specialty: <u>Obstetrics & Gynecology</u> City: <u>San Diego</u> State: <u>CA</u>		
Facility: <u>University of California - San Diego</u> PGY Year <u>4</u>	<u>07 / 2013</u>	<u>06 / 2014</u>
Specialty: <u>Obstetrics & Gynecology</u> City: <u>San Diego</u> State: <u>CA</u>		
Facility: _____ PGY Year _____ / _____ / _____		
Specialty: _____ City: _____ State: _____		

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination). If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

<u>Examination</u>	<u>Number of attempts</u>	<u>Passed (P) or Failed (E)</u>	
USMLE Step I	<u>1</u>	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step II	<u>1</u>	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step III	<u>1</u>	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
NBME Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 2	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Pre-1985	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part III	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 1	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 2	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 3	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
COMVEX	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC - Single	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC - Part I	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC - Part II	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
State Board Exam	_____	<input type="checkbox"/> P	<input type="checkbox"/> F
(State of examination and year)			

01
03
05
19

Hospital Affiliations and Employment

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

		From	To
Facility:	<u>University of California - San Diego</u>	<u>07/2010</u>	<u>06/2014</u>
Street:	<u>200 West Arbor Drive</u>	City: <u>San Diego</u>	State: <u>CA</u>
Facility:	_____	____/____/____	____/____/____
Street:	_____	City: _____	State: _____
Facility:	_____	____/____/____	____/____/____
Street:	_____	City: _____	State: _____
Facility:	_____	____/____/____	____/____/____
Street:	_____	City: _____	State: _____

- List other states (abbreviations) where you are currently or have ever had a full license CA
- Are you certified by the American Board of Medical Specialties? Yes No
 - Are you certified by the American Board of Osteopathic Medicine? Yes No
- List Board Certification(s): Anticipated written board exam June 30, 2014

4. List your practice specialt(ies) Obstetrics & Gynecology

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page 3) Yes No

6. Reason for requesting a Massachusetts medical license: I will be starting my Fellowship in Family Planning at Brigham & Women's Hospital starting 7/1/14.

7. Name of Facility: Brigham & Women's Hospital - Dept of OB/GYN, division of Family Planning
 Address: 1620 Tremont St, 4th floor City: Boston

8. Anticipated starting date in Massachusetts: 07/01/14

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

[Signature]
 Signature of Applicant

01 / 26 / 2014
 Month Day Year

- CURRICULUM VITAE -
Lynn Ly Ngo, MD
Department of Reproductive Medicine
University of California, San Diego

I. PERSONAL INFORMATION

Place of Birth: Worcester, Massachusetts
Home address and telephone:

Professional address and telephone:
University of California, San Diego
200 West Arbor Drive, Mail Code 8433
San Diego, CA 92103
619.543.6222 (paging operator)

Email:

II. PRESENT ACADEMIC RANK AND POSITION

Resident Physician, PGY-4
University of California San Diego Medical Center
Department of Reproductive Medicine

III. EDUCATION

College/University:
Massachusetts Institute of Technology
Bachelor of Science in Environmental Engineering
08/2002 – 06/2006

Medical School:
University of Hawaii John A. Burns School of Medicine
Doctor of Medicine
07/2006 – 05/2010

IV. POST GRADUATE EDUCATION

University of California, San Diego
Department of Reproductive Medicine, Internship
06/2010 – 06/2011

University of California, San Diego
Department of Reproductive Medicine, Residency
07/2011 – 06/2014

V. MEDICAL LICENSURES

Medical Board of California Medical License, *active*

- CURRICULUM VITAE -
Lynn Ly Ngo, MD
Department of Reproductive Medicine
University of California, San Diego

VI. HONORS AND AWARDS

North American Menopause Society Resident Reporter Award Recipient, October 2012

Alpha Omega Alpha Honor Society, 2010 to present

Yazawa Family Alpha Omega Honor Society Scholarship, awarded May 2010

Honors Credit, Obstetrics and Gynecology, Surgery, Internal Medicine, Psychiatry, Family Medicine, and Pediatrics Clerkships, 2008-2009

Japan Summer Exchange Program Scholarship Recipient, 2007

Howe-Walker Award, American Society of Civil Engineers, 2005

VII. RESEARCH

University of California, San Diego, Department of Reproductive Medicine, study in progress

- "Pain control for intrauterine device insertion: A randomized, double blind control trial of ketorolac prior to intrauterine device insertion."
- Mentor: Dr. Sheila Mody, Adjunct Assistant Professor
- Role: Lead Study Coordinator

University of California, San Diego, Department of Reproductive Medicine, October 2012

- Poster: Conolly, Jane; **Ngo, Lynn**; Miller, Christine; Kingston, Jessica. "Intracervical versus paracervical lidocaine for first trimester suction curettage without conscious sedation."
- Mentor: Dr. Jessica Kingston, Associate Clinical Professor
- Role: Created poster and presented it at the 2012 North American Forum on Family Planning in Denver, Colorado.

University of Hawaii, Department of Obstetrics and Gynecology, 2009-2010

- Publication: Tsai PJ, Nakashima L, Yamamoto J, **Ngo L**, Kaneshiro B. "Postpartum follow-up rates before and after the postpartum follow-up initiative at Queen Emma Clinic." Hawaii Medical Journal. 2011 March;70(3):56-9.
- Mentor: Dr. Bliss Kaneshiro, Assistant Professor, Director of Family Planning
- Role: Assistant Researcher, collected and organized data for analysis to determine the utility of photo albums to improve postpartum follow up rates

Massachusetts Institute of Technology, Department of Environmental Engineering, 2005-2006

- Publication: O.X. Cordero, H. Windschutte, B.C. Kirkup, S. Proehl, **L.Ngo**, F.A. Hussain, F. Le Roux, T. Mincer and M. F. Polz. "Ecological populations of bacteria act as units of antibiotic production and resistance." Science. 2012 Sep 7;337(6099):1228-31.
- Principle Investigator: Martin Polz
- Role: Assistant Researcher, aided in characterizing potential inter-species antibiotics for environmentally isolated strains of *Vibrio* with a novel characterization protocol and mentored other undergraduate researchers on basic laboratory techniques

- CURRICULUM VITAE -
Lynn Ly Ngo, MD
Department of Reproductive Medicine
University of California, San Diego

VIII. LEADERSHIP AND COMMITTEES:

Elected Administrative Chief Resident for the 2013-2014 academic calendar

- One of two elected residents to create the resident schedule
- Currently working alongside faculty members to solve administrative issues for all OB/GYN residents at UC San Diego
- Attended the CREOG/APGO Leadership Conference in Pasadena, CA in April 2013

San Diego House Staff Association, 2012 to 2013

- Committee Chair: Social Events and Promotion
- Organize monthly social events for resident physicians and promote the presence of the San Diego House Staff Association among fellow residents

Family Medicine Interest Group, Secretary, 2006-2008

- Organized community events such as Halloween carnivals for Oahu homeless shelters, blood pressure and glucose monitoring booths at health and craft fairs
- Organized medical school events such as injection workshops, residency panel, lecture by family medicine physicians

Hawaii Homeless Outreach and Medical Education (H.O.M.E.) Project, Manager, 2006-2008

- Managed the pharmacy at the H.O.M.E. project clinics, ensuring medications were in stock, organized, and distributed properly to patients
- Taught other medical students about clinic operations, kept supplies in stock, and transported equipment

IX. COMMUNITY SERVICE AND TEACHING

- Research project follow up presentation among faculty and residents. "Pain control for intrauterine device insertion: A randomized, double blind control trial of ketorolac prior to intrauterine device insertion." June 2013
- "Promotion of Contraception in the United States." Powerpoint presentation created for co-resident, who presented it at the 65th Congress of the Japan Society of Obstetrics and Gynecology. May 2013.
- "Review of updated 2012 ASCCP Guidelines." Journal club powerpoint presentation to fellow UC San Diego OB/GYN Residents. April 10, 2013.
- "Top three things I learned from the North American Menopause Society Meeting." Menopause lecture for UC San Diego OB/GYN Residents. February 6, 2013.
- Guidelines for prophylactic bilateral salpingo-oophorectomy during benign gynecological surgery, journal club presentation for Vietnamese Residents at Tu Du Hospital in Ho Chi Minh City, Vietnam. November 2012.
- Vaginal Birth After Cesarean, ACOG Bulletin, journal club presentation for Vietnamese Residents at Tu Du Hospital in Ho Chi Minh City, Vietnam. November 2012.
- Urogynecology Case Conference Presentation with emphasis on urethral diverticulum and colpocleisis cases. October 2012.

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University of California, San Diego

- REI Case Conference Presentation regarding Turner's Syndrome and pregnancy complications. June 2012.
- REI Case Conference Presentation regarding Asherman's Syndrome and infertility. May 2012.
- Research project presentation among faculty and residents. "Pain control for intrauterine device insertion: A randomized, double blind control trial of ketorolac prior to intrauterine device insertion." April 2012.
- Chapter Review among medical students and attending physician. Paul, Maureen, *et al.* "Chapter 11: Dilation and Evacuation." *Management of Unintended and Abnormal Pregnancies*. ©2009. Presented January 2012.
- Chapter Review among residents and attending physician. Paul, Maureen, *et al.* "Chapter 10: First trimester aspiration abortion." *Management of Unintended and Abnormal Pregnancies*. ©2009. Presented December 2011.
- Papaya IUD insertion and D&C Workshop, *Medical Students for Choice*, October 2011
- Article presentation among residents and Trauma fellow, "Transfusion Requirements after Cardiac Surgery: the TRACS Randomized Controlled Trial," *JAMA*. 2010;304(14):1559-1567. Presented June 2011.

X. MEMBERSHIP IN PROFESSIONAL SOCIETIES

American College of Obstetricians and Gynecologists, 2008-present
Alpha Omega Alpha Medical Honor Society, 2009-present
American Medical Association, 2010-present
North American Menopause Society, 2012-current
AAGL, 2013-present

XI. SKILLS

Languages: English, Vietnamese
Ethicon Laparoscopy Training Session Attendee, Cincinnati, OH June 18-19, 2012
Elective rotation at Tu Du Women's Hospital in Ho Chi Minh City, Vietnam, November 2012

SUPPLEMENT FORM


PRINT NAME: LYNN NGO DATE: 01/26/14

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS

YES NO

- 1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?
- 2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?
- 2-B. Have you ever, for any reason, been placed on probation or remediation by a medical school or any postgraduate training program?
- 3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?
- 4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?
- 5. Have you ever failed any of the following examinations: any Step of the USMLE, NBOME, FLEX, any State Board examination, any part of the National Boards, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?
- 6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?
- 6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
- 7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?
- 8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
- 8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?

Applicant's Signature:  Date: 01/26/14

YES NO

- 9-A. Have you ever voluntarily relinquished any medical staff membership?
- 9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
- 9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
- 9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
- 10. Have you ever been charged with any criminal offense, other than a minor traffic offense?
- 11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
- 12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?
- 13. Have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid; or have you ever been restricted from receiving payments from any Medicare, Medicaid (any state), or third party payors?
- 14. Have you ever had an application for membership as a participating provider rejected by any third-party payor?
- 15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
- 15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature:  Date: 01/26/14

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

MEDICAL EDUCATION VERIFICATION

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

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: [Signature] Date of Birth _____

Print or Type Name: NGO LYNN L Social Security No: _____
(Last name) (First Name) (Middle Initial)

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

Name of Medical School: University of Hawaii - John A. Burns School of Medicine

Address: 651 Iiala Street City: Honolulu State or Province: HI

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) to the applicant in a sealed envelope with the medical school seal affixed across the back of the envelope

APPLICANT'S EDUCATIONAL HISTORY

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

Pre-medical 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: Massachusetts Institute of Technology

Undergraduate School Address: 77 Massachusetts Ave, Cambridge MA 02139

(Continued on page 2)

Feb 17 2014 11:25am To: BOE 652 1251
SIR 5-3 5767
Received. FEB-12-2014 14:10 From: UCSD REPRO MED

Full License Application

Enrollment and Participation: Our records indicate that Ngo Lynn L
 (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
	07 / 24 / 2006	07 / 20 / 2007	07 / 06 / 2009	05 / 14 / 2010
	07 / 23 / 2007	05 / 30 / 2008	/ /	/ /
	06 / 23 / 2008	06 / 12 / 2009	/ /	/ /

The applicant attended 169 total weeks or _____ total months (must be included) of not less than 12 weeks in each academic year of continuing on-campus education.

check one was awarded a degree in Doctor of Medicine on (month/day/year) 05 / 15 / 2010

was NOI awarded degree. Please explain reason(s): _____

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

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?
5. Was the medical school education more than 4 years for U.S. graduates or more than 6 years for international graduates?

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: Marilyn Nishiki
 Print Name: Marilyn Nishiki
 Title: Registrar
 Date: 02 / 13 / 2014 Telephone: (808) 692-1004
 E-mail address: mnishiki@hawaii.edu

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

Seal Verified

DATE: 3/4

INITIALS: cm

Received: FEB-12-2014 14:10 F:\om\UCSD\REPRO\REC 5:19 5:13 5:57 10:30B 552 351

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: *Lynn Ngo* Date: 1/26/14
 Print or Type Name: LYNN NGO
 Name of Institution: University of California - San Diego

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: University of California San Diego
 If name of the institution was different when applicant attended, please enter name: _____
 Enrollment and Participation: Our records indicate that LYNN NGO participated in the following program
 (Print applicant's name)

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO		
Internship	1	OB/GYN	06/24/10	06/30/11	Yes	ACGME
Residency	2	OB/GYN	07/01/11	06/30/12	Yes	ACGME
Residency	3	OB/GYN	07/01/12	06/30/13	Yes	ACGME
Residency	4	OB/GYN	07/01/13	06/27/14	NO	ACGME

(Continued on page 2)

APPLICANT'S NAME: LYNN NGO

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of this postgraduate training program. Please circle the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS

YES NO

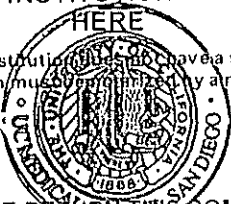
- 1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?
- 2. Was the applicant ever placed on probation?
- 3. Was the applicant ever disciplined or under investigation?
- 4. Were any negative reports ever filed by instructors regarding the applicant?
- 5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary issues?
- 6. During the applicant's participation, our postgraduate medical training program was accredited by: ACGME Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL

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



Program Director's Signature: *Christine Miller MD* M.D. D.O.
 Print Name: Christine Miller MD
 Academic Title: Clinical Professor
 Telephone: (619) 543 6777 Today's Date: 2, 3, 14
 E-mail address: cbmiller@ucsd.edu

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

Seal Verified
 DATE: 3/4
 INITIALS: pm



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Lynn L. Ngo, M.D.

License No.: 258634

Current Status: Active

License Expiration Date: 7/20/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 1620 Tremont Street
OBC 3-34
Boston
Massachusetts - 02120
United States of America

Home Address:

Business Address: 1620 Tremont Street
OBC 3-34
Boston
Massachusetts - 02120
United States of America
(617) 732-8798

3) Email Address:

4) Fax Number:

5) Specialties
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
California

9) States where you were previously licensed
None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Brigham & Women's Hospital	
Newton-Wellesley Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Lynn L Ngo, M.D.

License No.: 258634

11) Care of patients in Massachusetts
Average weekly hours involved in:

- a) inpatient care 2 hrs/wk
- b) outpatient care 24 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2014	06/30/2016	Claims made with tail coverage

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

14) Claims Made

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

15) Claims Closed

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

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Commonwealth of Massachusetts
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Physician Renewal Application

Physician Name: Lynn L Ngo, M.D.

License No.: 258634

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