90-Day Form

Dear Doctor,

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your full license is issued on January 1, 2014, you will be required to renew your full license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below and return this form with your Full License application.

Thank you.

Please select one of the boxes below:

☑ Do not hold my Full License Application; send it to the Board as soon as it is completed.

☐ Hold my Full License Application until it is within the 90-day time period.

My birthdate is _____ _____ _____
Month Day Year

Signature: Kathryn Smithing Today's Date: 2 / 1 / 17
Month Day Year

Please return this form with your Full License Application. If you do not submit this form with your Full License Application, your completed Full License Application will be forwarded to the Board for approval at the next Board meeting. Thank you.

270413

FEB 21 2017

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

FULL LICENSE APPLICATION

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

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)

Smithling | Katelyn | Rita | |
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: 1497069595

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

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: 3300 Main St Telephone: 413-794-7045
Number and Street

Springfield | MA | 01107
City | State/Province/Territory | Zip (or postal) Code

E-mail Address: Fax number: 844-310-1513

Are you applying for licensure through FCVS? ☐ **Yes** ☒ **No**

*** The Board will use your Mailing Address for all correspondence**

Date Received: 2/21/17

Check #: 310

Check Amount: $ 600.00

Initials: CM

Pre-medical School **From** **To**

Name: Cornell University Degree: BS Year: 2002 Year: 2006
Street: B07 Day Hall City: Ithaca State: NY

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

Medical School

Name: Columbia University College of Physicians + Surgeons Degree: MD
Street: 630 W 168th St City: New York State: NY

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

Medical School Graduation Date: 5 / 2010
Month 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: Women's Infants Hospital of RI PGY Year: 1-4 6 / 2010 6 / 2014
Specialty: Obstetrics + Gynecology City: Providence State: RI

Facility: MedStar Washington Hospital Center PGY Year: 5-7 7 / 2014 6 / 2017
Specialty: Female Pelvic Medicine + Reconstructive Surgery City: Washington State: DC

Facility: _____ PGY Year: _____ / _____ / _____
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ / _____ / _____
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ / _____ / _____
Specialty: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. 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.

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

Hospital Affiliations and Employment

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

N/A

		From	To
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: DC MD
2. a) Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☑ No
3. List Board Certification(s): American Board of Obstetrics + Gynecology
4. List your practice specialt(ies): Obstetrics + Gynecology, Female Pelvic Medicine + Reconstructive Surgery
5. Have you completed the Opioid and Pain Management training? (See Instructions) ☑ Yes ☐ No
6. Have you completed training to recognize and report suspected child abuse or neglect? ☑ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)
7. Reason for requesting a Massachusetts medical license: Beginning employment at Baystate Health as specialist in Female Pelvic Medicine + Reconstructive Surgery
8. Name of Facility: Baystate Health
   Address: 3300 Main St City: Springfield
9. Anticipated starting date in Massachusetts: 9 / 1 / 17
10. 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.

Katelyn Smithling
Signature of Applicant

2 / 1 / 17
Month Day Year

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Katelyn Smithling
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Katelyn Smithling
Applicant's Signature

2/1/17
Date of Signature

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

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

___ Participation in a Meaningful Use program as an eligible professional;
_✓_ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
___ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
___ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

___ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
___ for an Administrative License;
___ for a Volunteer License;
___ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
___ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: Katelyn Smithberg DATE: 2/1/17

PRINT NAME: Katelyn Smithling DATE: 2/1/17

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
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 been placed on probation or remediation by a medical school, graduate 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 or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: Katelyn Smithling DATE: 2/1/17

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever 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, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, 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 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 had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever 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?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Katelyn Smithling DATE: 2/1/17

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. 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 impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Katelyn Smithling DATE: 2/1/17

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

Applicant's Signature: Katelyn Smithling Date: 2/1/17

PRINT NAME: Katelyn Smithling DATE: 2/1/17

For all questions, please attach additional pages, whenever necessary, using the same format.

QUESTIONS #1, 8A, 8B – Disciplinary action.

Name of agency or institution taking action: _____ Date: ___/___/___

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to any disciplinary action. Documents should be sent directly to you in a sealed envelope.

QUESTION #2-A or 2-B – Medical school or any postgraduate training termination, leave of absence, withdrawal, repeating a year of training, probation, or remediation.

Name of institution: _____

State or Country: _____ Dates of attendance: From: ___/___/___ To: ___/___/___

Date of action: ___/___/___

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any leave of absence, withdrawal, failure to complete, requirement to repeat, termination, probation, or remediation. Documents should be sent directly to you in a sealed envelope.

QUESTION #3 – Medical school more than 4 years for U.S. or Canadian graduates or more than 6 years for international medical graduates.

Name of institution: _____ Date: ___/___/___

State or Country: _____ Dates of attendance: From: ___/___/___ To: ___/___/___

Explanation: _____

PRINT NAME: Katelyn Smithling DATE: 2/1/17

QUESTION #4 – Examination denial; improper conduct.

Name of organization: _____ Name of exam: _____

Action: _____ Date: ____/____/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any examination denial or improper conduct. Documents should be sent directly to you in a sealed envelope.

QUESTIONS #5 & 6 – Medical license application denial or withdrawal; license surrender or revocation.

Describe circumstances under which license application was withdrawn or denied, or license was surrendered or revoked.

State: _____ Year: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any medical application denial or withdrawal and any license surrender or revocation. The documents must specify the reason(s) and should be sent directly to you in a sealed envelope.

QUESTION #7 – ABMS or AOA certification denial, suspension, or revocation.

Specialty Board: _____ Date: ____/____/____

Explain reason(s) for loss or denial: _____

Please contact the certifying board to provide a letter explaining the reason(s) for the denial, suspension, or revocation. The letter should be sent directly to you in a sealed envelope.

PRINT NAME: Katelyn Smithling DATE: 2/1/17

QUESTIONS #9-A, 9-B, 9-C – Medical staff membership, status, privileges or association with a health care facility.

Name of facility: _____ Date: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 9-A through 9-C. Documents should be sent directly to you in a sealed envelope.

QUESTION #10 – Criminal Offenses.

Court: _____ Charge(s): _____ Date: ___/___/___

Describe the circumstances leading up to criminal proceedings. _____

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the indictment, complaint, judgment or other disposition in any criminal proceeding in which you were a defendant. Documents should be sent directly to you in a sealed envelope.

QUESTION #11 – Controlled substances privileges.

Type of restriction: _____ Date: ___/___/___

Describe the circumstances of restriction: _____

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact, and correspondence related to any suspension, revocation, denial, restriction or surrender of controlled substance privileges. Documents should be sent directly to you in a sealed envelope.

PRINT NAME: Katelyn Smithling DATE: 2/1/17

QUESTIONS #12 &13– Liability insurance provider, third party payor, Medicare and Medicaid (any state).

Name of Organization: _____ Date of action: ___/___/___

Action: _____

Describe reason(s) for action: _____

_____

_____

_____

_____

_____

_____

You must arrange for your liability carrier or appropriate institution or agency to submit documents regarding any restrictions, denials, or revocations. Documents should be sent directly to you in a sealed envelope.

PRINT NAME: Kaitlyn Smithling DATE: 2/1/17

QUESTION #14-A – Malpractice claims.

For each instance of alleged malpractice, you must provide the following information.

Claimant's name:_____ Date of incident:____/____/____

Insurer's name:_____

Insurer's Address:_____

Description of claim (allegations only: this does not constitute an admission of fault or liability).

Allegation:_____ Allegation:_____ Allegation:_____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient's condition at point of your involvement:_____

2. Patient's condition at end of treatment:_____

3. The nature and extent of your involvement with the patient:_____

4. Your degree of responsibility for the course of treatment leading to the claim:_____

5. If incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

6. Legal representative's name:_____
   Address:_____ Telephone:_____
   City:_____ State:_____ Zip:_____

(Question #14-A continued on next page)

PRINT NAME: Katelyn Smithling DATE: 2/1/17

QUESTION #14-A (continued)

Current status of claim: ☐ Closed ☐ Pending

Was the case resolved before the entry of a verdict? ☐ Yes ☐ No

What was the decision? ☐ Dismissed before trial ☐ Plaintiff Verdict ☐ Defense Verdict

Decision determined by: ☐ Judge ☐ Jury

If a payment was made: Amount allocated to you: $_____ Payment Date: ____/____/____

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

QUESTION #14-B – Civil lawsuits (other than medical malpractice).

Plaintiff's name: _____ Date: ____/____/____

Your legal representative's name: _____

Description of claim (this does not constitute admission or liability): _____

_____

_____

_____

_____

_____

Outcome of lawsuit: _____

PRINT NAME: Katelyn Smithling DATE: 2/1/17

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #15 – Medical condition.

If you answered "yes" to Question 15, please provide the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program.

QUESTION #16 – Substance use.

If you have obtained medical treatment related to your use of substances, please provide the specifics of your treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

QUESTION #17 - Refusal to take a screening test for chemical substances.

If you answered "yes" to Question 17, please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

Sealed Envelope
Initials: KY

Seal Verified
DATE: 2-22-17
INITIALS: KY

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public**.

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Katelyn Smithling
(name of applicant)

for 2.5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Katelyn Smithling
Signature of applicant

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

Signature of Notary

My commission expires

DANIELLE G. ARNOLD
NOTARY PUBLIC
District of Columbia
My Commission Expires
February 14, 2021

DISTRICT OF COLUMBIA NOTARY PUBLIC EXP - 02/14/21

Signature of Certifying Physician

MD041349 — License Number
DC — State

Lee Ann Richter
Type or print name clearly

Address: 106 Irving St NW
Suite 405 South
City: Washington State: DC Zip: 20010
Telephone: (202) 877-6526
Date: 2/1/17

***Instructions to the certifying physician**: Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.*

GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

CURRICULUM VITAE

Katelyn R. Smithling, MD, FACOG
Female Pelvic Medicine and Reconstructive Surgery
Department of Obstetrics and Gynecology
MedStar Georgetown University Hospital
106 Irving St NW, Suite 405 South
Washington, DC 20010
Phone fax (844) 310-1513

1. PERSONAL INFORMATION

A. Education:

Undergraduate:	Cornell University, Ithaca, USA, 2002-2006, B.S., Nutritional Sciences
Medical Education:	Columbia University College of Physicians and Surgeons, New York, USA, 8/2006-5/2010, M.D.
Residency:	Women and Infants Hospital of RI, Obstetrics and Gynecology, Warren Alpert School of Medicine of Brown University, Providence, USA, 6/2010-6/2014, Maureen Phipps, M.D., M.P.H
Fellowship:	MedStar Georgetown University Hospital, Female Pelvic Medicine and Reconstructive Surgery and Minimally Invasive Gynecologic Surgery, Washington D.C., USA, 7/2014-present, Cheryl Iglesia, M.D.

B. Professional Experience:

1. Instructor of Clinical Obstetrics and Gynecology, Georgetown University School of Medicine, Washington, USA, 112016 – present
2. Clinical Fellow, MedStar Washington Hospital Center and MedStar Georgetown University Hospital, Washington, USA 7/2014 - present
3. Clinical Instructor, Warren Alpert School of Medicine, Brown University, Providence, USA, 6/2010-6/2014

C. Licensure:

1. Maryland: License number D77328, 2/28/2014 – 9/30/2017
2. District of Columbia: License number MD042075, 3/20/2014 – 12/31/2018

D. Certification:

Board Certification: American Board of Obstetrics and Gynecology, 11/6/2015 – 12/31/2016

Board Eligible: Female Pelvic Medicine and Reconstructive Surgery

Planned Written examination date: 6/23/2017

Planned Oral examination: by 2019

Fundamentals of Laparoscopic Surgery: 1/9/2016
BLS/ACLS certification: American Heart Association, 12/19/2014 – 12/18/2016
Da Vinci System: 9/6/2016

E. Languages Spoken: English

2. RESEARCH AND SCHOLARLY ACTIVITIES

A. Publications:

i. Original Papers in Refereed Journals

1. **Smithling KR**, Savella G, Raker CA, Matteson KA. Preoperative uterine bleeding pattern and risk of endometrial ablation failure. Am J Obstet Gynecol. 2014 Nov;211(5):556.e1-6. doi: 10.1016/j.ajog.2014.07.005. Epub 2014 Jul 11. PubMed PMID: 25019488.

2. Iglesia, CB and **Smithling, KR.** Pelvic Organ Prolapse. American Family Physician. Accepted for publication, 2016 Aug.

3. **Smithling KR,** Antosh, DD, Tefera E, Iglesia CB. De novo Dyspareunia and Sexual Function Assessment Using Two Sexual Questionnaires. Submitted to J Reprod Med, 2016 Dec.

ii. Reviews or Editorials in Refereed Journals

1. **Smithling KR,** Sokol AI. What to do with the vaginal apex at the time of hysterectomy: Optimal technique. OBG Management. 2015 Oct; 27(Suppl) S14-19.

2. **Smithling KR** and Iglesia, CB. Innovations in Incontinence: Diagnosis and Treatment of OAB. Consultant. 2015 Dec;55(12):982-987.

iii. Other Publications

1. **Smithling KR,** Sokol, AI. Chapter 10: Complications of FPMRS Surgery. FPMRS study guide. Submitted to McGraw Hill, Jan 2015.

2. **Smithling, KR,** Richter LA, Gutman RE. Postoperative care plan after vesicovaginal fistula repair for Kibagabaga Hospital, Rwanda. International Organization for Women and Development, Inc. June 2016.

iv. Abstracts for Conference papers and posters

1. Mirza FG, **Smithling KR,** Bauer ST, Veer AVD, Laifer-Narin SL, Simpson LL. Am J Obstet Gynecol. 2009 Dec;201(6S) S123.

2. Pilzek A, **Smithling KR**, Myers DM. Two Unique Methods for Excision of Eroded Mersilene Suburethral Sling and their Unique Complications – A retrospective case study. Female Pelvic Med Reconstr Surg. 2013 Sept-Oct;19(2S):S162.

3. **Smithling KR,** Savella G, Raker CA, Matteson KA. Preoperative uterine bleeding pattern and risk of endometrial ablation failure. J Minim Invasive Gynecol. 2014 Mar-Apr;21(2S):S10.

4. **Smithling KR,** Antosh, DD, Tefera E, Iglesia CB. De novo Dyspareunia and Sexual Function Assessment Using Two Sexual Questionnaires. J Minim Invasive Gynecol. 2015 Mar-Apr;22(3S):S23-24.

5. **Smithling KR, Rubin R, Iglesia CB.** Anatomy of the Female Sexual Response. Female Pelvic Med Reconstr Surg. 2015 Sept/Oct;21(5 Supp 1) S147–S156.

6. **Smithling KR**, Iglesia CB. Tips and Tricks for Open Laparoscopy. Am J Obstet Gynecol. 2016 Apr;214(4 Supp 1):S513.

7. **Smithling KR**, Tran AM, Davé BA, Chu CM, Chan RC, Antosh DM, Gutman RE. Efficacy Of Repeat Mid-Urethral Sling For Persistent Or Recurrent Stress Urinary Incontinence: A Fellows Pelvic Research Network Study. Poster accepted to Society of Gynecologic Surgeons 43rd Annual Scientific Meeting, 2017.

B. Research Funding:

i. Current Active

1. Title of Project: Treatment of Refractory Overactive Bladder with OnabotulinumtoxinA vs. PTNS: TROOP trial

Dates of Project Period: 4/2015-4/2016

Identifying Number: IRB 2014-277

Agency: International Urogynecological Association (IUGA) Research Grant 2015

Corresponding PI: Katelyn Smithling, MD

Mentors: Cheryl Iglesia, MD and Robert Gutman, MD

Project summary: Multicenter prospective cohort study comparing PTNS and intradetrusor for refractory OAB using validated questionnaires for 3-month and 12-month follow-up

Total Direct Costs over all years of award: $ 15,000

Total Direct plus Indirect Costs over all years of award: $15,000

2. Title of Project: Treatment of Refractory Overactive Bladder with OnabotulinumtoxinA vs. PTNS: TROOP trial

Dates of Project Period: 5/8/15 – 6/30/17

Agency: MedStar Washington Hospital Center GME

Identifying Number: IRB 2014-277

Corresponding PI: Katelyn Smithling, MD

Project summary: Multicenter prospective cohort study comparing PTNS and intradetrusor for refractory OAB using validated questionnaires for 3-month and 12-month follow-up

Total Direct Costs over all years of award: $ 10,000

Total Direct plus Indirect Costs over all years of award: $0

C. Current Active Projects (non-funded)

1. Title of Project: Efficacy of repeat mid-urethral sling for persistent or recurrent stress urinary incontinence

Dates of Project Period: 8/2014 – present

Agency: Fellows Pelvic Research Network

Identifying Number: IRB 2014-192

Corresponding PI: Katelyn Smithling, MD

Project summary: Multicenter retrospective review of women with repeat midurethral slings with prospective phone follow-up to obtain UDI-6 scores

2. Title of Project: Voiding dysfunction after surgeries for pelvic floor disorders

Dates of Project Period: 11/2015 – present

Agency: MedStar Washington Hospital Center GME

Identifying Number: IRB 2015-241

Corresponding PI: Katelyn Smithling, MD

Project summary: Retrospective chart review to assess the rates of voiding dysfunction after surgery for prolapse and incontinence amongst physicians at the National Center For Advanced Pelvic Surgery. This project also aims to identify risk factors for acute urinary retention after passing a void trial, and to describe the course of patients who have severe retention (PVR >1 liter) on representation.

3. Title of Project: Acceptability of urinary diversion for inoperable vesicovaginal fistula in Rwanda

Dates of Project Period: 8/2016 – present

Agency: College of Medicine and Health Sciences, Kigali, Rwanda and International Organization for Women and Development, Inc.

Identifying Number: approved, IRB number pending

Corresponding PI: Katelyn Smithling, MD and Denis Rwabizi, MD

Project summary: Observational questionnaire study to assess acceptability of urinary diversion procedures amongst women with inoperable vesicovaginal fistulae at Kibagabaga Hospital in Kigali Rwanda

D. Invited Lectures:

1. Preoperative Uterine Bleeding Pattern and Risk of Endometrial Ablation Failure, Oral presentation, 40th Annual Scientific Meeting of the Society of Gynecologic Surgeons, March 2013.

2. Pelvic Organ Prolapse, Resident lecture, MedStar Washington Hospital Center/Georgetown University Department of Obstetrics and Gynecology, August 2014

3. Surgery for Pelvic Organ Prolapse, Grand Rounds, Georgetown University Hospital Department of Urology, Washington, D.C., September 2014

4. De novo Dyspareunia and Sexual Function Assessment Using Two Sexual Questionnaires, Oral poster presentation, 41st Annual Scientific Meeting of the Society of Gynecologic Surgeons, Orlando, FL, March 2015

5. Anatomy of the Pelvis, Resident lecture, MedStar Washington Hospital Center/Georgetown University Department of Obstetrics and Gynecology, August 2014

6. Anatomy of the Female Sexual Response, Oral presentation, 36th Annual Scientific Meeting of the American Urogynecologic Society, October 2015

7. Approach to Pelvic Organ Prolapse, Grand Rounds, MedStar Montgomery Medical Center, March 2016

8. Anatomy of the Female Sexual Response, Video presentation, American College of Obstetricians and Gynecologists Annual Clinical & Scientific Meeting, May 2016

9. Pelvic Organ Prolapse and Urinary Incontinence, Perioperative Nursing In-service, MedStar Montgomery Medical Center, June 2016

10. Female Pelvic Anatomy Lecture and Lab, Georgetown University Hospital Department of Urology, Washington, D.C., July 2016.

3. TEACHING, MENTORING, AND ADVISING

A. Teaching Activities

i. Medical School Clerkships

Name of Clerkship: Obstetrics and Gynecology, Warren Alpert School of Medicine, Brown University
Role: Assistant Clinical Instructor
Number of Direct Contact Hours*: 30
Year(s) Taught: 6/2010 – 6/2014
Number of Students/Fellows: 2 per rotation
Overall Evaluation Score: 4/5
Average number of Medical students you train per year: approximately 20

Name of Clerkship: Obstetrics and Gynecology, Georgetown University School of Medicine
Role: Clinical fellow
Number of Direct Contact Hours*: 12
Year(s) Taught: 7/2014 – present
Number of Students/Fellows: 8 per rotation
Overall Evaluation Score: n/a
Average number of Medical students you train per year: approximately 40

ii. Teaching Recognition/Awards

Excellence in Teaching Award, Warren Alpert Medical School of Brown University, Year
Award Name, 2014

B. Mentorship

Mentor: Katelyn Smithling
Name of Mentee: Celine Yeh
Dates of Mentorship: 2015
Project: Treatment of Refractory Overactive Bladder with OnabotulinumtoxinA vs. PTNS: TROOP trial (see Resarch Funding, active projects #1)

Mentor: Katelyn Smithling
Name of Mentee: Nemi Shah
Dates of Mentorship: 2016
Project: Efficacy of repeat mid-urethral sling for persistent or recurrent stress urinary incontinence (see Current active projects #1)

Mentor: Katelyn Smithling
Name of Mentee: Leslie Andriani
Dates of Mentorship: 2016
Project: Efficacy of repeat mid-urethral sling for persistent or recurrent stress urinary incontinence (see Current active projects #1)

Mentor: Katelyn Smithling
Name of Mentee: Mouri Siddique
Dates of Mentorship: 2016 – present
Project: Voiding Dysfunction After Surgeries For Pelvic Floor Disorders
(see Current active projects #2)

Mentor: Katelyn Smithling
Name of Mentee: Patricia Mwesigwa
Dates of Mentorship: 2016 – present
Project: Voiding Dysfunction After Surgeries For Pelvic Floor Disorders
(see Current active projects #2)

4. SERVICE

A. MedStar or Hospital Service

1. Member, OB/GYN Practice committee, 9/2015 – present.

5. HONORS AND AWARDS

1. Outstanding Senior, Cornell University, College of Human Ecology, 2010

2. Merrill Presidential Scholar - outstanding seniors who rank among the top 1% of their class, Cornell University, 2006

3. Honors in Primary Care, Surgery, OBGYN, Neurology, Pediatrics, Psychiatry, Internal Medicine, Nephrology, Pharmacology, Pathophysiology I and II, Psychiatric Medicine II, Columbia University College of Physicians and Surgeons, 2008-2010

4. Doctor Harold Lee Meierhof Memorial Prize – for excellence in Pathology over the four years in medical school, Columbia University College of Physicians and Surgeons, 2010

5. Glasgow-Rubin Achievement Award – presented to women students graduating in the top 10 percent of their Class, Columbia University College of Physicians and Surgeons, 2010

6. Alpha Omega Alpha Honor Society, Columbia University College of Physicians and Surgeons, 2010

7. AUGS Resident Award for Excellence in Female Pelvic Medicine and Reconstructive Surgery, Women and Infants Hospital of RI, 2013

8. David H. Nichols Award for Excellence in Pelvic Surgery – presented to best surgeon in graduating residency class, Women and Infants Hospital of RI, 2014

9. Society of Gynecologic Surgeons Winning Spirit Award – presented to FPMRS fellow who best demonstrates the core values of collaboration, caring, high performance, and winning spirit, Society of Gynecologic Surgeons Annual Scientific Meeting, 2016

10. 3rd prize for Best Video, American College of Obstetricians and Gynecologists Annual Clinical & Scientific Meeting, 2016

6. PROFESSIONAL SOCIETY MEMBERSHIP

2014 – present, Fellows Pelvic Research Network
2014 – present, Society for Gynecologic Surgeons
2012 – present, American Urogynecologic Society
2011 – present, American Association of Gynecologic Laparoscopists
2010 – present, Alpha Omega Alpha Honor Society
2009 – present, American College of Obstetricians and Gynecologists

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

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: Katelyn Smithling Date of Birth: ____ ____ ____

Name (Please type or print): Smithling (Last Name) Katelyn (First Name) R (Middle Initial)

Other Name(s) (Please type or print.): _____

Name of Medical School: Columbia University College of Physicians + Surgeons

Address: 650 W 168th St, Room 141 Black Bldg City: New York State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. 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: _____

Undergraduate School Address: _____

Enrollment and Participation:

Our records indicate that Smithling (Last name) Katelyn (First name) R. (Middle initial)
(Print the applicant's name):

attended our medical school for a total of 160 weeks (must be included) of continuous medical education on the following dates from 08/28/2006 to 05/18/2010.
month/day/year month/day/year

This applicant:

Check one: ☑ **was awarded the** degree of Doctor of Medicine on 05/18/2010
month/day/year

☐ **will be awarded** the degree of _____ on ____/____/____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because: _____

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. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?		
2. Was the applicant ever placed on probation or remediation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation for any of the above questions _____

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: [signature]

Print Name: Charles Dempsey

Title: Assistant Dir of Registration + Student Financial Svcs.

Date: 02/16/20 Telephone: (212) 342-4790

E-mail address: cumc-rfs@columbia.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 envelope. Thank you.

Seal Verified
DATE: 2-22-17
INITIALS: KY

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

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: Katelyn Smithling Date: 1/30/17

Print or Type Name: Katelyn Smithling

Name and Address of Institution: Women + Infants Hospital of Rhode Island
101 Dudley St
Providence, RI 02905

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: Women & Infants Hospital

Name of Institution, if different when applicant attended: _____

Verification for: KATELYN SMITHLING
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Internship	1	OB/GYN	6/24/2011	6/23/2011	Y	ACGME
Residency	2	OB/GYN	6/24/2011	6/23/2012	Y	ACGME
Residency	3	OB/GYN	6/24/2012	6/23/2013	Y	ACGME
Residency	4	OB/GYN	6/24/2013	6/23/2014	Y	ACGME
		4/4/17	/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: Katelyn Smithling

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **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 postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____

Print Name: Gary Frishman

Academic Title: Program Director

Telephone: (401) 274 1122 EXT 41446 Today's Date: 1/31/2017

E-mail address: GFrishman@WIHRI.org

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

Seal Verified DATE: 4/2017 INITIALS: _____

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

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: Katelyn Smithling Date: 11/27/17

Print or Type Name: Katelyn Smithling

Name and Address of Institution: MedStar Washington Hospital Center
106 Irving St NW, Suite 405 South
Washington DC 20010

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: MedStar Washington Hospital Center / Georgetown University

Name of Institution, if different when applicant attended: _____

Verification for: Katelyn Smithling
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) FROM	TO	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Fellowship	PGY5-7	OB/GYN - Female Pelvic Medicine and Reconstructive	7/1/14	6/30/17	In Progress	ACGME
		Surgery (FPMRS)	/ /	/ /		
Fellowship	PGY5	FPMRS	7/1/14	6/30/15	yes	ACGME
"	PGY6	FPMRS	7/1/15	6/30/16	yes	ACGME
"	PGY7	FPMRS	7/1/16	6/30/17	In progress	ACGME

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

4/3/17

APPLICANT'S NAME: Katelyn Smithling

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **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 postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____ MD

Print Name: Robert E Gutman MD

Academic Title: Program Director, FPMRS, Associate Professor OB/GYN + Urology

Telephone: (702) 877 6536 Today's Date: 2/13/17

E-mail address: Robert.e.gutman@unlv.edu

4/3/17

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

Seal Verified
DATE: 2-22-17
INITIALS: KV

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

MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of your current and all past liability carrier(s). You must provide your malpractice history reports if you ever had a full license in any state. You do not need to supply your malpractice history reports while participating in an ACGME postgraduate training program unless you had a full license or you were named in a malpractice case. This form must be returned to the Board with your license application.

Please provide the following information on the malpractice history report:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: Please report any open or closed cases that have gone to trial, whether or not monies were paid, and provide a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant. If the applicant does not have any claims history, please indicate that on your letterhead. If your company's name has changed, please provide any former company names. The information should be sent to the applicant.

Liability Carrier: MedStar Health, Inc. Risk Management Finance Plan From: 6 /2014 To: 6 /2017
City: Columbia State: MD Policy #: 112701-00-16

Liability Carrier: Marsh, USA, Inc From: 12 /2014 To: 1 /2018
City: New York State: NY Policy #: 6793286

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy #: _____

Applicant's signature: Kaitlyn Smithling 4 / 3 / 17 Date

Print Name: Katelyn Smithling

Address: _____

City: _____ State: _____ Zip code: _____

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

Katelyn Smithling, MD

2/16/17

Board of Registration in Medicine
200 Harvard Mill Square, Suite 300
Wakefield, MA 01880

Dear Board of Registration in Medicine:

Please find enclosed my application of medical license in the state of Massachusetts. All requested documents are enclosed, with the exception of:

1. State License Verification—District of Columbia: will be sent directly to the Massachusetts Board of Registration in Medicine from the DC Department of Health.
2. State License Verification—Maryland: transmitted electronically to the Massachusetts Board of Registration in Medicine on 1/27/17
3. Postgraduate Verification form—Residency: mailed from Women and Infant's hospital of RI to the Massachusetts Board of Registration in Medicine.

Please contact me if there is any missing or incomplete information.

Sincerely,

Katelyn Smithling

Katelyn Smithling, MD

Government of the District of Columbia

Department of Health

Health Regulation and Licensing Administration

LICENSURE VERIFICATION

Date: **February 15, 2017**

RE: **KATELYN R. SMITHLING**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a **MEDICINE AND SURGERY** license by the District of Columbia Board of Medicine. It is further certified that:

The license number is **MD042075** and was issued on **03/20/2014**.

The current license status is **Active**.

The license expiration date was/is **12/31/2018**.

BOARD ACTIONS

A review of public records indicates that **0** public orders have been docketed. Access to public records may be viewed online at www.doh.dc.gov/bomed

Additional Information:_____

_____

_____

Certified this day February 15, 2017 SEAL

Sharon W. Lewis, DHA, RN-BC, CPM
Interim Senior Deputy Director
Health Regulation and Licensing Administration

Sent Via Email _____to_____
Sent Via Mail or FedEx _____

899 North Capitol St. NE, 2nd Flr.| Washington, DC, 20002 |T: 202 724-8800 | F: 202 442-8117
www.doh.dc.gov/bomed| www.facebookcom/dc.bomed

Seal Verified
DATE: 4/20/17
INITIALS: ae

STATE OF MARYLAND

DHMH Board of Physicians

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

April 1, 2017

Massachusetts Board of Medicine
200 Harvard Mill Square
Suite 330
Wakefield MA 01880-32

This is to verify the records of the Maryland Board of Physicians. The following information is available under the Maryland Public Information Act, State Government Article, Section 4-333, regarding the following practitioner:

Katelyn Rita Smithling

For the Practice of:	Physician-M.D.
License Number:	D77328
Date Issued:	**02/28/2014**
Current Status:	**Active**
Expiration Date:	**09/30/2017**
*Disciplinary Actions:	**No disciplinary actions.**

**Disciplinary information can be found on our website. Go to https://www.mbp.state.md.us and select Search Practitioner Profiles.*

For malpractice claim information, please contact the Maryland Health Care Alternative Dispute Resolution Office 410.767.8200.

Respectfully,

Maryland Board of Physicians
Verification Unit

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Katelyn R Smithling, M.D. **License No.:** 270413

Current Status: Active **License Expiration Date:** 6/8/2018

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:
3300 Main St
Suite 4B
Springfield
Massachusetts - 01107
United States of America
(413) 794-7045

3) Email Address:

4) Fax Number: (844) 310-1513

5) Specialties
Female Pelvic Medicine and Reconstructive Surgery
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
None Reported

9) States where you were previously licensed
District of Columbia
Maryland

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
Baystate Medical Center	

Noble Hospital

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Medical Center Self Insured	10/01/2017	10/01/2018	Claims made with tail coverage

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

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

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

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

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

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

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

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

Physician Name: Katelyn R Smithling, M.D. **License No.:** 270413

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

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

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

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

Physician Name: Katelyn R Smithling, M.D. **License No.:** 270413

Office Based Surgery

Please indicate your office Facility Classification under the MMS office Based Surgery Guidelines

You indicated that you are a Level I office

Compliance with Legal Responsibilities

Online profile:
☒ I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

☒ **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.**