Glenn
1/11/01
#2046

Application #: 209125
Date of Issue: 6/13/01

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor
Boston, MA 02111 - (617) 727-3086

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

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

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

☒ M.D. ☐ D.O. ☐ Ph.D ☒ Other degree MPH

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.)

Date of Birth: ____ ____ ____ (Month Day Year) Social Security Number: _____

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

Home Address: _____
Number and Street

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

Business Address: BOSTON MEDICAL CENTER DEPT OB/GYN, MAT-3
Number and Street ONE BMC PLACE

BOSTON MA 02118
City State/Province/Territory Zip (or postal) Code

Business Telephone: (617) 414-5167, ext. - Home Telephone: (____) _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

APPLICANT'S NAME: ANGELA YINGCHE CHEN

Pre-medical School

Facility: BOSTON UNIVERSITY Degree: BA From FALL/90 To MAY 97
Street: COLLEGE OF ARTS & SCIENCES City: BOSTON State: MA

Facility: BOSTON UNIVERSITY Degree: MPH FALL/93 MAY/97
Street: SCHOOL OF PUBLIC HEALTH City: BOSTON State: MA

Medical School

Facility: BOSTON UNIVERSITY Degree: MD From FALL/93 To MAY/97
Street: 80 E. NEWTON ST City: BOSTON State: MA
SCHOOL OF MEDICINE

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 5/1997

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: BOSTON MEDICAL CENTER Position: PGY1-4 From 7/1/1997 To 6/30/2001
Street: ONE BMC PLACE City: BOSTON State: MA

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

APPLICANT'S NAME: ANGELA YINGCHE CHEN

Hospital Affiliations and Employment

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

		From	To
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
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 been licensed: ___ ___ ___
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): ______
4. Have you attached an up-to-date copy of your curriculum vitae? ☐ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: ______

______

6. Name of Facility: ______
7. Address: ______ City: ______
8. Anticipated starting date in Massachusetts: 08 / 01 / 2001

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

[signature]
Signature of Applicant

12.15.00
Date

PHONE • CELL • E-MAIL ANGELA.CHEN@BMC.ORG

ANGELA YINGCHE CHEN

EDUCATION

1990 - 1997 Boston University, College of Liberal Arts Boston, MA

BA, Major in Medical Sciences, Minor in Psychology

- Seven Year Combined BA/MD Program, Dean's List, BU Founders Merit Scholarship, Pomona Valley Hospital Medical Center Scholarship, Women's Club of Claremont Merit Scholarship

1993 - 1997 Boston University, School of Public Health Boston, MA

MPH, Concentration in Health Services

- Combined MPH/MD Program

1993 - 1997 Boston University, School of Medicine Boston, MA

MD,

- Student government representative, Founder student note transcription service, Founder BU chapter Asian American Medical Association

1997 - present Boston Medical Center Boston, MA

Internship and Residency in Obstetrics and Gynecology

- 1999 Best resident teacher award

WORK EXPERIENCE

1993 - 1994 Boston University, Dept. of Anatomy Boston, MA

Histology Teaching Assistant

1993 - 1994 Boston University, Dept. of Psychology Boston, MA

Statistics Teaching Assistant

1992 - 1993 Boston Public Library Boston, MA

Librarian's Assistant, Department of Government Documents

PROFESSIONAL MEMBERSHIPS

American College of Obstetrics and Gynecology, Junior Fellow

National Association of Asian American Professionals

LANGUAGES

Intermediate Spanish, Basic Chinese (Mandarin and Taiwanese)

Accepted
Ael Rose
5/23/01

ka

Commonwealth of Massachusetts--Board of Registration in Medicine
19 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

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. This statement should be executed by someone other than a relative who has known you for a substantial period of time. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH

Attach a recent 2 x 2

a

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

Kathleen McCluskey

Kathleen McCluskey

Signature of Notary 4/16/01

4/16/2004

My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

ANGELA YINGCHE CHEN

(name of applicant)

for 3 1/2 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. 4/16/01

4/16/01 Angela Chen

Angela Y Chen

Signature of applicant

Phillip G. Stubblefield MD

Signature of Certifying Physician

35488 — License Number

MA — State

PHILLIP G. STUBBLEFIELD MD

Type or print name clearly

Address: 91 E. CONCORD ST - MAT 3

City: BOSTON

State: MA Zip: 02118

Telephone: (617) 414-5175

Date: 12/18/00

INSTRUCTIONS TO CERTIFYING PHYSICIAN: ***PLEASE RETURN THIS FORM DIRECTLY TO THE BOARD OF REGISTRATION IN MEDICINE.***

Commonwealth of Massachusetts Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were licensed in the past.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registation in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: Angela Y. Chen Date: 12/15/00

Print or type name: ANGELA Y. CHEN

License number: 5842 Status of license: ☒ Active ☐ Inactive ☐ Other LIMITED LICENSE TO SERVE AS RESIDENT

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: _____
2. Date of graduation: ___/___/___ License number: _____ Date of issue: ___/___/___
3. Basis for licensure: _____
   Name(s) of medical licensing examinations(s).
4. Expiration date of license: ___/___/___
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

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

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

BOARD SEAL

Signed: _____
Print Name: _____
Title: _____
State Board: _____ Date: ___/___/___

PLEASE RETURN DIRECTLY TO THE MASSACHUSETTS BOARD OF REGISTRATION

OB/GYN

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

ARGEO PAUL CELLUCCI
GOVERNOR

JANE SWIFT
LIEUTENANT GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

CERTIFICATE OF LIMITED REGISTRATION
(under G.L. c. 112, sec. 9)

License Number: 5842

This is to certify that ANGELA Y CHEN, M.D. has been granted Limited Registration to serve as Resident with authority to practice medicine only in Boston Medical Center and affiliates. Service at the hospital begins on 07/01/1997. Expected date of completion of program will be 06/30/2001. This license automatically terminates at the end of each academic year, unless the conditions for annual issuance are met pursuant to 243 CMR 2.02 (2).

THIS CERTIFICATE DOES NOT ENTITLE ANGELA Y CHEN, M.D. TO PRACTICE IN THE ABOVE HOSPITAL AFTER 07/01/2001.

Peter N. Madras, M.D., Secretary

Seal

Board Approval Date(s)
06/04/1997
06/15/1998
04/30/1999
05/23/2000

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

MALPRACTICE HISTORY

Applicant's Instructions : Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. Please return the form(s) with your original signature to the Board of Registration in Medicine.

Waiver for Release of Information

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amount 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.

RECEIVED
MAY - 8 2001
Board of Registration in Medicine

NOTE: IF THE APPLICANT HAS ANY OPEN OR CLOSED CASES WHERE MONIES HAVE BEEN PAID, A COPY OF THE COMPLAINT OR SUMMONS, DISPOSITION OR JUDGEMENT AND AMOUNT OF MONIES PAID ON BEHALF OF THE APPLICANT MUST BE FOWARDED DIRECTLY TO THE BOARD.

Dates of Issue

Liability Carrier: PROMUTUAL **From:** 7/97 **To:** 6/2001
City: BOSTON State: MA
Policy Number: 1-25547

Liability Carrier: _____ **From:** ____/____ **To:** ____/____
City: _____ State: _____
Policy Number: _____

Liability Carrier: _____ **From:** ____/____ **To:** ____/____
City: _____ State: _____
Policy Number: _____

Please forward the information requested to the Board of Registration in Medicine at the address above.

Signed: Angela Y. Chen 5/7/2001
Date

Print Name: ANGELA Y. CHEN

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
10 WEST STREET, BOSTON, MA 02111 - (617) 727-3086

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, ANGELA YINGCHE CHEN
(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
10 West Street, Boston, MA 02111
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 must be sent directly by the persons to the Board of Registration in Medicine. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me.

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

Applicant's Signature

12.15.00
Date of Signature

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

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

Application #: 97-5842-01
Date Approved: 6 / 15 / 98

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTION A: Sections A and C on page 2 are to be completed by applicant.

1. Name: (Last) CHEN (First) ANGELA (MI) Y
2. Mailing Address: _____ Telephone Number: _____
   City, State and Zip: _____
3. Name of Training Hospital: BOSTON MEDICAL CENTER
4. Current Limited License Number: (97-5842-99)
5. Other states (abbreviations) where you are now fully licensed to practice medicine: _____

TO BE COMPLETED BY PROGRAM DIRECTOR

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

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Phillip G. Stubblefield, M.D. Date: 6/5/98

Signature of Program Director: Phillip G Stubblefield MD Telephone: 617-534-5167

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

This certifies that Angela Chen, M.D. (Name of Applicant) has been appointed to the

position of: ☐ Intern ☒ Resident ☐ Fellow

Program Name: Obstetrics/Gynecology Facility: Boston Medical Center

Beginning Date: 07 / 01 / 97 Anticipated Completion Date of Training: 06/30/2001

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

Designated Official: Maxine Kessler (Print Name) DIR OF GRAD. Med. Education (Title) Telephone: 617-534-5423

Designated Official's Signature: Maxine Kessler Date: 6 / 9 / 98

RECEIVED
JUN 11 1998
REGISTRATION

DATE: 6/11/98
INITIAL: KM
FEE: $50.00 Check

NAME: ANGELA Y. CHEN

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

SINCE YOUR LAST RENEWAL	YES	NO
16. Have you been granted a leave of absence or withdrawn from a post-graduate training program?		
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating or improper conduct during an examination?		
18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19. Have you voluntarily surrendered a license to practice medicine or any healing art?		
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (national, international, state or local)?		
21. Has any disciplinary action (see definition) been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?		
24. Have you voluntarily relinquished medical staff membership?		
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26. Have you been charged with any criminal offense, other than a minor traffic offense?		
27. Has your privilege to possess, dispense or prescribe controlled substances been restricted, revoked, denied or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency regarding such privileges?		
28. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to 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?		

NAME: ANGELA Y CHEN

CONFIDENTIAL MEDICAL INFORMATION

SINCE YOUR LAST RENEWAL:

		YES	NO
30.	Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician? (See instructions)		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician? (See instructions)		
32.	In the past year, have you suffered memory loss or impaired judgment for any reason?		
33.	Within the past year, have you engaged in the use of drugs or alcohol with the result that your ability to practice medicine is currently limited or impaired?		
34.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of alcohol or drugs?		
35.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
36.	Within the past year, have you voluntarily modified or otherwise limited your practice for any reason other than a medical condition?		

If your responses to Questions 16-36 change while your application is pending, you must make the Board aware of the new information.

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 M.G.L. c. 119, § 51A, I certify that I will fulfill my obligation to report abuse or neglect of children. I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: _____ **Date:** 6/3/98

Revised: 11/24/97
E/license/renlimit

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.

97-5842-99

CHECK ONE:

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

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) CHEN (First) ANGELA (MI) Y

1-B. Other Name(s)

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

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

2. Current Residence: _____ Telephone Number: _____

_____

3. Date of Birth (Mo/Da/Yr): ____ ____ ____ Place of Birth: _____

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

6. Name and address of Massachusetts Training Hospital: BOSTON MEDICAL CENTER

ONE BOSTON MEDICAL CENTER PLACE, BOSTON MA 02118-2393

MAY 12 1997
56 50-

NAME: ANGELA Y. CHEN

7. Name of premedical school(s) BOSTON UNIVERSITY, College of Arts & Sciences

   Location: BOSTON MA USA
   (City, State, Country)

8. Name of medical school(s) BOSTON UNIVERSITY SCHOOL OF MEDICINE

   Location: BOSTON MA USA
   (City, State, Country)

   Year of Graduation 1997 Degree Received: M. D. ☒ D. O. ☐ Other (specify)_____

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

   Name of Institution: _____

   Address: _____

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

10. List states (abbreviations) where you are currently licensed to practice medicine:

    _____ _____ _____ _____ _____

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):

    _____ _____ _____ _____ _____

12. Medical School Training:

	YES	NO
a) If you are a USMG, have you taken more than 4 years to complete medical school?		
b) If you are an IMG, have you taken more than 6 years to complete medical school?		

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

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?
    If **yes**, you must provide additional information. (See instructions.)

NAME: ANGELA Y. CHEN

	YES	NO
14. Have you ever been enrolled in a residency training program(s) that you did not complete? **If yes, a letter from your program director is required.** (See instructions.)		

Explanation attached?_____ Program Director's Certification requested? _____

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

	YES	NO
15. Since your matriculation in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program?		
17. Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		

NAME: ANGELA Y. CHEN

	YES	NO
21. Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24. Have you ever voluntarily relinquished medical staff membership?		
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26. Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

NAME: ANGELA Y. CHEN

CONFIDENTIAL MEDICAL INFORMATION

		YES	NO
30.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician? (See instructions.)		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician? (See instructions.)		
32.	In the past year, have you suffered memory loss or impaired judgment for any reason?		
33.	Within the past two years, have you engaged in the use of drugs or alcohol with the result that your ability to practice medicine is currently limited or impaired?		
34.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of alcohol or drugs?		
35.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
36.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 15-36 change while your application is pending, you must notify the Board of the new information immediately.

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 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 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: Angela Y. Chen **Date:** 4/6/97

NAME: ANGELA Y. CHEN

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

This certifies that Angela Y Chen (Name of Applicant) has been appointed

to the position of ☑ Intern ☐ Resident ☐ Fellow

in the Obstetrics & Gynecology (BUMC)
(Name of Program)

at Boston Medical Center
(Name of Hospital)

beginning 01/07/97 (date) to anticipated completion of training: 06/30/2001 (date)

	YES	NO
Is the program accredited by the ACGME?	☑	☐
If **no**, is there an ACGME-approved training program in the applicant's specialty?	☐	☐

Designated Official's Signature: Mayine Kessler

Type or Print Name and Title: MAYINE KESSLER, DIR. OF GME

Date: 5/7/97 Telephone Number: 534-5423

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

LIMITED

RECEIVED
APR 14 1997
BOARD OF REGISTRATION IN MEDICINE

FORM E CONTINUED

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

NAME OF APPLICANT ANGELA Y. CHEN

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

FROM: MONTH	DAY	YEAR	TO: MONTH	DAY	YEAR
9/7/93			6/17/94		
8/29/94			5/8/95		
7/3/95			6/23/96		
6/24/96			5/4/97		

AND HAS RECEIVED/WILL RECEIVE A DEGREEE OF DOCTOR OF MEDICINE

ON MAY 18, 1997.

Rachel H. Paquette
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

RACHEL H. PAQUETTE, REGISTRAR
NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE: APRIL 10, 1997

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

LIMITED

FORM E

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it DIRECTLY TO THE ADDRESS ABOVE. This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT ANGELA Y. CHEN CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

BOSTON UNIVERSITY, BOSTON, MA SEVEN YEAR PROGRAM
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: BOSTON UNIVERSITY SCHOOL OF MEDICINE
NAME OF MEDICAL SCHOOL

80 E. CONCORD ST. BOSTON, MA 02118 USA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT ANGELA Y. CHEN
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: BOSTON UNIVERSITY SCHOOL OF MEDICINE
NAME OF MEDICAL SCHOOL

CONTINUED ON BACK OF THIS PAGE

DATE: 4-27
INITIAL: LLS
FEE: $50.00 Check 246

RECEIVED
APR 21 1999
BOARD OF REGISTRATION IN MEDICINE

Application #: 97-5842-01
Date Approved: 4/30/1999

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

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

Section A:

1. Name: (Last) CHEN (First) ANGELA (MI) Y
2. Mailing Address: _____ Telephone Number: _____
   City, State and Zip: _____
3. Name of Training Hospital: Boston Medical Center
4. Current Limited License Number: 97-5842-01
5. Other states (abbreviations) where you are now fully licensed to practice medicine: _____ _____ _____

Section B: To be completed by program director.

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

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Phillip Stubblefield, M.D. Date: 4/9/99

Signature of Program Director: _____ Telephone: 617-414-5767

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Angela Y. Chen (Name of Applicant) has been appointed to the position of: ☐ Intern ☑ Resident ☐ Fellow as a PGY 3

Program Name: Obstetrics & Gynecology Facility: Boston Medical Center

Beginning Date: 7/1/97 Anticipated Completion Date of Training: 6/30/2001

Is the program accredited by the ACGME: ☑ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Maxine Kessler Director, GME (Print Name) (Title) Telephone: 617-414-5423

Designated Official's Signature: _____ Date: 4/20/99

NAME: ANGELA CHEN

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

		YES	NO
SINCE YOUR LAST RENEWAL			
16.	Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?		
17.	Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18.	Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19.	Have you voluntarily surrendered a license to practice medicine or any healing art?		
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21.	Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).		
22.	Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you voluntarily relinquished medical staff membership?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26.	Have you been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

NAME: ANGELA CHEN

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

SINCE YOUR LAST RENEWAL:

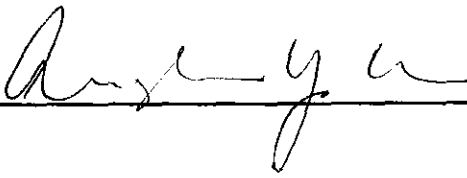
		YES	NO
30.	Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

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

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 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 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature:  **Date:** 4/9/99

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
10 WEST STREET, BOSTON, MA 02111 - (617) 727-3086

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, ANGELA CHEN
(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
10 West Street, Boston, MA 02111
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 must be sent directly by the persons to the Board of Registration in Medicine. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me.

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.

Angela Y. Chen — 4.9.99
Applicant's Signature — Date of Signature

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

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

RECEIVED
MAY - 9 2000
Board of Registration in Medicine

pd
216
5/23/00
me

Application #: 5842
Date Approved: 5/23/00

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

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

SECTION A:

1. Name: (Last) CHEN (First) ANGELA (MI) Y
2. Mailing Address: BOSTON MEDICAL CENTER - Mat 3 One Boston Medical Center Place Telephone Number:
   City: Boston State: MA Zip: 02118
3. Name of Training Hospital: BOSTON MEDICAL CENTER
4. Current Limited License Number: 97-5842-01
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

SECTION B: To be completed by program director.

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

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Phillip G. Stubblefield, M.D. Date: 4/6/00

Signature of Program Director: [signature] MD Telephone: 617-414-5592

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Angela Chen has been appointed
(Name of Applicant)

to the position of: ☐ Intern ☑ Resident ☐ Fellow as a PGY 4

Hospital Name: Boston Medical Center Specialty: Obstetrics & Gynecology

Beginning Date: 07/01/00 Anticipated Completion Date of Training: 06/30/01

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

Designated Official: Maxine Kessler (Print Name) Director, OME (Title) Telephone: 617-414-5483

Designated Official's Signature: [signature] Date: 5/4/00

NAME: ANGELA Y. CHEN

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

	YES	NO

SINCE YOUR LAST RENEWAL

Note: These questions apply only since your last renewal.

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

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

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

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

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

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

24. Have you voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

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

27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

NAME: ANGELA Y. CHEN

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

SINCE YOUR LAST RENEWAL:

Note: These questions apply only since your last renewal.

		YES	NO
30.	Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 16-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

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 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 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: Angela Y. Chen **Date:** 3/18/00

Revised: 01/04/2000
E/share/forms/renlim2000

SUPPLEMENT FORM

Name: ANGELA YINGCHE CHEN Date: 12/15/00

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

		YES	NO
1.	Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2.	Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
3.	Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
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: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners 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 certification 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)?		

Print Name: ANGELA YINGCHE CHEN

		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 suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
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?		
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: Angela Y Chen **Date:** 12/15/00

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on pages 9 and 10. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

	YES	NO
16-A. Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
16-B. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
17-A Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently impaired or limited?		
17-B. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
18. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
19. Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

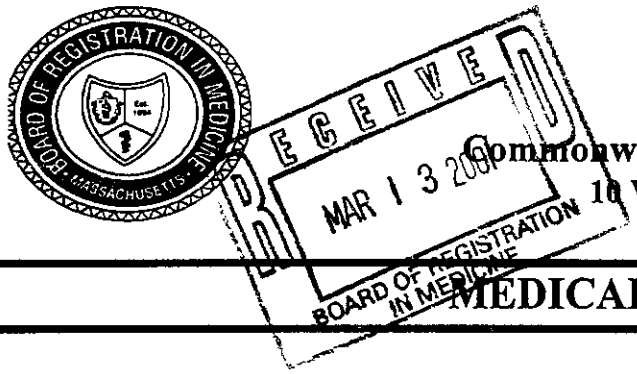
If your responses to Questions 1-19 change while your application is pending, you must immediately notify the Board of the new information.

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 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 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for full licensure in Massachusetts.

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

Applicant's Signature: Angela Y Un **Date:** 12/15/00



Commonwealth of Massachusetts Board of Registration in
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-308

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your unive university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical educatior ***Massachusetts Board of Registration in Medicine.***

Applicant's Signature: Angela Y Chen Date of Birth: ____ Social Securit

Name of Medical School: BOSTON UNIVERSITY SCHOOL OF MEDICINE

Address: 715 Albany Street City: Boston State or Province: MA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the applicant's official transcript (which indicat and hours of attendance, and scores, grades, or evaluations) directly to the Board of Registration in Medicine.

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: BOSTON UNIVERSITY

Undergraduate School Address: 881 COMMONWEALTH AVE. BOSTON, MA 02215

Enrollment and Participation: *Our records indicate that*

CHEN, ANGELA

(type/print applicant's name: last, first, middle, suffix)

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

ATTENDANCE DATES:	FROM	TO	FROM
	9 / 7 / 93	6 / 17 / 94	6 / 24 / 96
	8 / 29 / 94	5 / 8 / 95	/ /
	7 / 3 / 95	6 / 23 / 96	/ /

The applicant attended 144 total weeks of continuing on-campus education, not less than 32 weeks in each acad

check one [X] was awarded a degree in DOCTOR OF MEDICINE on (month/day/year)

[ ] was NOT awarded degree. Please explain reason(s).

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

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?

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

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

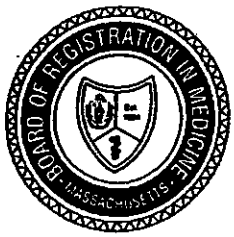
INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

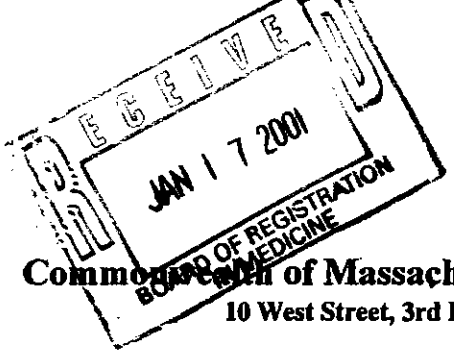
Signature: Ellen J. DiFiore

Print Name: ELLEN J. DIFIORE

Title: REGISTRAR

Date: 3 / 9 / 01 Telephone: (617)6





POST

Commonwealth of Massachusetts--Board of Registration in M
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below to be for Board of Registration in Medicine.

Applicant's Signature: Angela Y Chen Date:

Print or Type Name: ANGELA YINGCHE CHEN

Name of Institution: BOSTON MEDICAL CENTER

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registration in Medicine at the address above. If the department was program, please submit documentation of the rotations, dates and hours of training to the Board.

Name of Institution: Boston medical Center

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that ANGELA CHEN participated
(type or print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Compl (YES/
Intern	1	OB/Gyn	7 1 97	6 130 98	Ye
Resident	P2-4	OB/Gyn	7 1 98	6 130 101	will c
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

APPLICANT'S NAME: ANGELA CHEN MD

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

QUESTIONS	**YES**
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?	
2. Was the applicant ever placed on probation?	
3. Was the applicant ever disciplined or under investigation?	
4. Were any negative reports ever filed by instructors regarding the applicant?	
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	

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

COMMENTS:

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

Program Director's Signature:

Print Name: PHILIP G. STUBBLEF

AFFIX INSTITUTIONAL SEAL HERE

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

Academic Title: PROFESSOR

Telephone: (617) 414-5775 Today's Date: 1

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Rec'd 7-25-02

COMPLETED

Physician Registration Renewal Application

RECEIVED JUL 25 2002 BOARD OF REGISTRATION IN MEDICINE

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

- **Remit $400.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required.

1. Current Status: Active Registration No.: 209125 Renewal Date: 08/04/2002

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
Angela Y Chen
Boston Medical Center, MAT 3
91 East Concord Street
Boston, MA 02118

B) Home Address:

Home Phone:

Business Phone: (617)414-5167

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (_____) _____

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (_____) _____
PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: b) Sex: F
c) SS#:

5.a) Name of Medical School:
Boston University School of Medicine
b) Year Graduated: 1997 M.D. c) Degree:

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.
086	80
	0
	0

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: Code:

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)
_____ _____ _____ _____ _____ _____ _____ _____
b) States where you were previously licensed (Abbr.)
_____ _____ _____ _____ _____ _____ _____ _____

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 530/✓ (AP) 100 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: ___/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: CHEN LICENSE NUMBER: 209125

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: _____ Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☑ Yes ☐ No

13. A. What is your principal work setting? (See Table 4) 10 25

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 10 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 40 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege 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 or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☐ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☑ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 7/24/02

YOU MUST SIGN AND INCLUDE PART B. WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING

PRINT YOUR LAST NAME: CHEN LICENSE NUMBER: 209125

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Boston Medical Center Ins. Co. Ltd. Alternatively, indicate as follows: (a)
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☑ Yes ☐ No

13. A. What is your principal work setting? (See Table 4) 10 25

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 10 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 40 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege 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 or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☐ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☑ CME exemption

See Instructions for CME requirements. **Do not submit documentation of your CMEs with your renewal application.**

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. **NOTE:** This applies even if you reside out-of-state or out of the United States.

- *Pursuant to G.L. c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.*
- *Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.*
- *I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.*

Signature: _____ Date: 7/24/02

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS: **YES** **NO**

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.

Signature: _____ Date: 7/24/02

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

Physician Registration Renewal Application

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *at least 4 weeks* before your renewal date.

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 209125 Renewal Date: 08/04/2004

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
Angela Y Chen
UCLA
10833 Leconte Ave., 27-139
Los Angeles, CA 90095

B) Home Address:

RECEIVED
JUL - 6 2004
Board of Registration in Medicine

Home Phone:

Business Phone: (310)206-3306

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (_____) _____

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (_____) _____

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

4. a) Date of Birth: b) Sex: F
c) SS#:

5. a) Name of Medical School:
Boston University School of Medicine
b) Year Graduated: 1997 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
~~OBG~~ OBG	~~80~~ 0	~~Obstetrics and Gynecology~~

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: Code:

8. Drug License Numbers, if
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)
CA
b) States where you were previously licensed (Abbr.)

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

Facility Code: 998/N (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Chen LICENSE NUMBER: 209125

11. My medical malpractice insurance is covered by ☐ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required):_____ Policy dates: From: ___/___/___ To:___/___/___

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☒ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption:_____

12. What is your principal work setting? (See Table 4) 4 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).
    1) Average weekly hours involved in: A) inpatient care 0 hrs/wk B) outpatient care 0 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. CLAIMS MADE (New or Pending): Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. CLAIMS (Resolved): Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege 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 or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: _____ Date: 6/30/04

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

PRINT NAME AND NUMBER: Last Name: CHEN License Number: 209125

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the period since you signed your last renewal application. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS: **YES** **NO**

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

I hereby certify under the penalties of perjury that all the information on this Renewal Application, Part B and Form R is true.

Signature: _____ Date: 6/30/04

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING