

The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH, DIVISION OF FOOD AND DRUGS
305 SOUTH STREET, JAMAICA PLAIN, MA 02130



REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

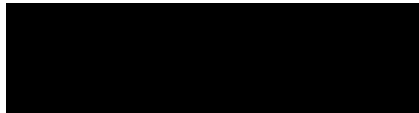
NUMBER
MM0386943A

ISSUED
05/15/03

TYPE
CONTROLLED SUBSTANCES PRACTITIONER
SCHEDULES
II, III, IV, V, VI

ISSUED TO

MUENZER, MATTHIAS G MD



A handwritten signature in cursive script, reading "Christine Ferguson".

COMMISSIONER OF PUBLIC HEALTH

FILE COPY

254981

ADDRESS CHANGE



Matthias G. Muenzer, MD



Monday, July 21, 2003

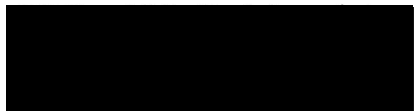
To
The Commonwealth of Massachusetts
Department of Public Health, Division of Food and Drugs
305 South ST
Jamaica Plain, MA 02130

RE: Change of Office Address
Controlled Substances License: MM0386943A

To Whom It May Concern:

Please note that my office address will change, effective immediately.
My new office address will be:

Matthias G. Muenzer MD

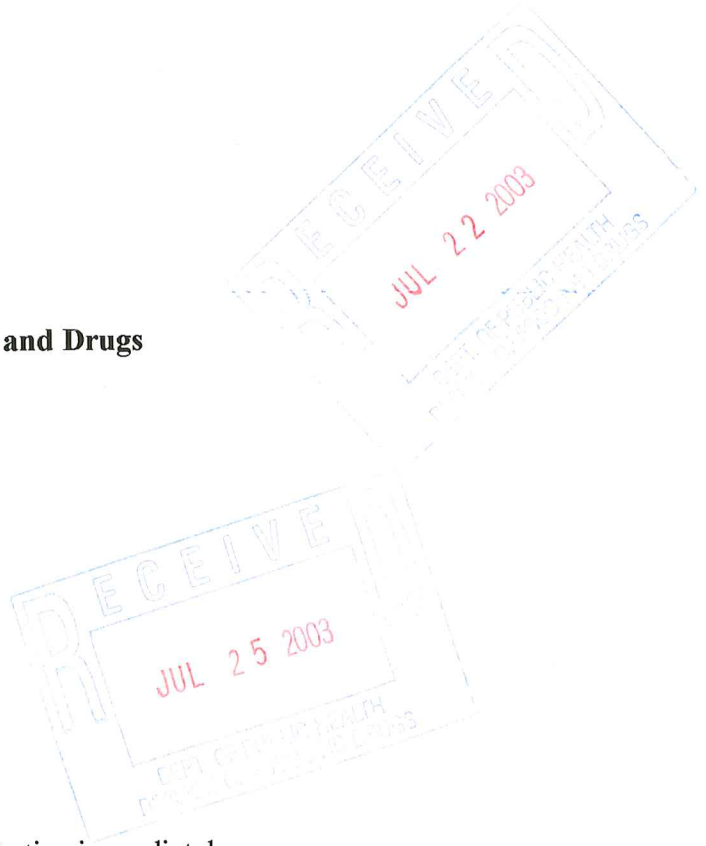


My home address remains the same, as above 

Thank you very much,
Sincerely yours

A handwritten signature in cursive script that reads "Matthias Muenzer".

Matthias Muenzer MD



The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH, DIVISION OF FOOD AND DRUGS
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COMMISSIONER OF PUBLIC HEALTH

258176

RECIPIENT'S COPY

RECALL



COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

ISSUES THIS LICENSE TO

Matthias G Muenzer M.D.



AS A REGISTERED PHYSICIAN

160382

08/26/2004

REGISTRATION NO.

EXPIRATION DATE



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130-3597
(617) 983-6700 (617) 524-8062 - Fax

Your application is being returned for the reason(s) checked below:

7/22/03

	REASON FOR RETURN	ADDITIONAL COMMENTS AND/OR INSTRUCTIONS
1.	<input type="checkbox"/> Please check all drug schedules that apply.	
2.	<input type="checkbox"/> A copy of a TPA letter is required for your initial registration. If you do not have one, please contact the Board of Optometry at 617-727-3093.	
3.	<input type="checkbox"/> You must sign your application. <input type="checkbox"/> You must sign your check.	
4.	<input type="checkbox"/> Your social security number is required.	
5.	<input type="checkbox"/> A check in the amount of \$150.00 and made payable to The Commonwealth of Massachusetts is required must accompany your application.	
6.	<input type="checkbox"/> A Massachusetts business address is required. A post office box is not acceptable. Please include the Department (i.e. Pediatrics).	
7.	<input checked="" type="checkbox"/> A copy of your current Massachusetts Medical License (small wallet card issued by the Board of Registration in Medicine or appropriate board) must accompany your application.	
8.	<input type="checkbox"/> Our records indicate that you have an existing registration. <input type="checkbox"/> Second location is not necessary	
9.	<input type="checkbox"/> Other	

S: Bureau/Admin/Application Forms/PHYOPT return sheet

7/23/03

Copy enclosed Thank you
Mr. [unclear]