

APR 17 2012

06/14/12 528

Application #: 252081

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

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a \$100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE: Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
 Graduate of an International Medical School (IMG)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) Schimmoller (First) Natasha (MI) R

1-B. Other Name(s): _____

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|-------------------------------------|
| 1) Have you ever been known under a different name or combination of names? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2) Have you ever been licensed under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

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

3. Date of Birth: _____ Place of Birth: _____
Month Day Year

E-mail Address: _____

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

6. Name of Massachusetts Training Program: Residency in Obstetrics and Gynecology, Boston University medical Center
One Boston Medical Center Place Boston, MA 02118
Street Address (City)

Date received: 4/17/12
Check #: 100408053
Check Amount \$ 100
Totals:

Natasha Schimmoeller

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

This certifies that Natasha Schimmoeller has been appointed
(Name of Applicant)

to the position of Intern Resident Fellow

in the specialty of Obstetrics and Gynecology as a PGY 1

Department: Ob/Gyn Subspecialty: Ob/Gyn

at Boston Medical Center
(Name of Healthcare Facility)

beginning 6 / 18 / 2012 to anticipated completion of training: 6 / 30 / 2014
(Month) (Day) (Year) (Month) (Day) (Year)

YES NO

1. Is the program accredited by the ACGME?

2. If **no**, is there an ACGME-approved training program in the applicant's specialty?

3. Have you reviewed Sections A and C of the limited license application? Yes

Designated Official's Signature: Maxine E. Kessler

Type or Print Name: Maxine E. Kessler

Official Title: Director of Graduate Medical Education

Date: 4 / 5 / 12 Telephone Number: 617-414-5423

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



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Natasha Rita Schimmoeller
(type/print your complete name)

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

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

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

Immunity and Release

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

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken.

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

Natasha Schimmoeller
Applicant's Signature

03/21/2012
Date of Signature

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

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

Natasha R. Schimmoeller

Education

Obstetrics and Gynecology Residency Training Program, Boston Medical Center, Boston, MA
June 2012 - June 2016

Doctor of Medicine - New York Medical College, August 2008 - June 2012

Master of Public Health, Global Health - New York Medical College, August 2008 - June 2012

Master of Arts, Bioethics - Case Western Reserve University, August 2007- May 2008

Bachelor of Arts, Public Health - Case Western Reserve University, August 2004- May 2008

Honors and Awards

New York (Downstate) Medical Student Representative, ACOG District II Junior Fellow Advisory Council (2011-2012): Chosen by ACOG District II Junior Fellow Executive Committee to work with advisory council members to improve medical student obstetrics and gynecology education. Sponsored to attend ACOG District II Annual Meeting 2011 and ACOG Annual Clinical Meeting 2012.

Infectious Diseases Society of America Medical Scholars Program (2010-2012): Funded project "Sensitivity of U.S. vs. European Serologic Test Kits for Detection of Borrelial Antibodies in Patients who Acquired Lyme disease in Europe vs. U.S." under guidance of Dr. Gary Wormser (NYMC) and Dr. Gerold Stanek (Medical University of Vienna, Austria). Will determine if U.S. serologic kits can diagnose Lyme disease acquired in Europe and vice versa.

Experiential Learning Fellowship, Case Western Reserve University (2008): Provided financial support to go to South Africa and undertake personal senior project, "From Curriculum to Community Advocacy: A Multi-Institutional Comparison of HIV/AIDS Education Models in Cape Town, South Africa".

Peter Witt Scholarship, Case Western Reserve University (2007): Awarded to undergraduates who exhibit strong community involvement among underserved populations in Cleveland, Ohio.

Research Experience

Infectious Disease Summer Fellowship Program, NYMC (2009-2012): Worked with Dr. Gary Wormser to analyze serologic changes among patients with past history of Lyme disease. Also gained clinical experience at NYMC Lyme Disease Diagnostic Center, diagnosing/treating patients and enrolling them into Lyme disease studies.

Research Assistant, Case Comprehensive Cancer Center, CWRU (2007-2008): Worked with Jill Barnholtz-Sloan, Ph.D. in a study utilizing the Surveillance Epidemiology and End Results (SEER)/Medicare cancer database to investigate gender differences in Small Cell Lung Cancer survival.

Off Nicotine Primary Care Grant, CWRU Department of Medicine (2006-2007): Worked with Dr. Scott Frank to translate his group tobacco-cessation program into a one-on-one model that physicians could use to counsel patients toward stopping smoking. Framed tobacco use as a clinical condition, measured by an exhaled carbon monoxide meter and treated through a four-visit counseling series and nicotine replacement therapy.

Employment Experience

International Bioethics Education Programs, CWRU (2005-2008): Helped organize international bioethics trips for undergraduates. Served as in-country coordinator and bioethics teaching assistant, traveling to courses held in the Netherlands, France, Spain, and Argentina.

JamesCare for Life, James Comprehensive Cancer Center, The Ohio State University (2005): Assisted with support services for cancer patients and caregivers, from inpatient art and music therapy to cancer education and bereavement groups.

Extracurricular Activities

Women's Health Clinic, La Casita de la Salud, NYMC Student-Run Clinic, Harlem (2010-2011): Medical student preceptor and member of clinical care team at newly established Women's Health Clinic; provided basic gynecologic care to underserved population.

Ob/Gyn Interest Group, NYMC (2009-2011): Held events to connect students to the field of Ob/Gyn and increase awareness regarding Women's Health issues. Attended ACOG Annual Clinical Meeting 2011.

'La Casita de la Salud' NYMC Student-Run Clinic, Harlem (2008-2011): Served as Community Resources Chair and remain a clinical care team volunteer in general medical clinic.

Infectious Disease Interest Group, NYMC (2009-2010): Founded group in order to support students interested in the field of Infectious Diseases and to carry out related events such as World AIDS Day observance activities and conference attendance.

Improve Healthcare, NYMC (2008-2010): Mediated student discussions at medical school regarding pressing issues in healthcare, providing background education and expert speakers.

HIV Test Counselor, Free Clinic of Greater Cleveland (2005-2007): Did rapid HIV testing for patients who came to walk-in clinic and provided pre and post-test counseling.

Poster Presentations

"Stage-related Differences in Incidence and Survival for Individuals with Primary Invasive Small Cell Lung Cancer", Research Poster Session, American Society of Preventive Oncology Annual Meeting (2008), Washington D.C.

Oral Presentations

"Case Presentation: Giant Basal Cell Carcinoma", Morbidity and Mortality Conference (June 2011), Department of Surgery, Bronx-Lebanon Hospital Center, New York, NY.

“Health Disparities in East Harlem: How knowledge about barriers to health can lead to more effective patient care”, La Casita de la Salud Annual Cultural Competency Training (February 2010), New York Medical College, Valhalla, NY.

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

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university of graduation for verification. **Please Note: Fourth year medical students must include the letter to the medical school with 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: Natasha Schimmoeller Date of Birth: _____

Print or Type Name: Schimmoeller Natasha R Social Security No. _____
(Last name) (First Name) (Middle Initial)

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

Name of Medical School: New York Medical College

Address: 40 Sunshine Cottage Road City: Valhalla State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above named applicant has not been awarded a degree. Please include a transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the medical school in a separate 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: Case Western Reserve University

Undergraduate School Address: N/A

Continued on page 2

Enrollment and Participation: Our records indicate that

Natasha Schimmoeller R
(type or print the applicant's name): (Last name) (First name) (M

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

<u>ATTENDANCE DATES:</u>			<u>FROM</u>			<u>TO</u>			<u>FROM</u>														
	08	/	04	/	08		06	/	30	/	09		07	/	05	/	11		05	/		/	
	08	/	17	/	09		06	/	27	/	10			/		/				/		/	
	06	/	28	/	10		06	/	30	/	11			/		/				/		/	

The applicant attended 161 total weeks (must be included) of continuing on-campus education, not less than 32 weeks in ea

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

will be awarded on 05 / 31 / 12 (Form B must also be completed and returned di

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

YES

1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?


COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Seal Verified 5/14/12
DATE: _____
INITIALS: LMF

Signature: 

Print Name: Judith A. Ehren

Title: Associate Provost/University Registrar

Date: 04 / 02 / 12 Telephone: (914) 594-44

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

LMC

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that Natasha Rita Schimmoeller
(Student's Name)

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

from New York Medical College
(Name of Medical School)

and will receive the degree on 05 / 31 / 2012.

Signature of Certifying Official: 
(Original Signature is required - Stamps not accepted)

Printed Name: Judith A. Ehren

Title: Associate Provost/University Registrar

Date: 05/29/2012

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



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

1. Training Program

Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: BMC Office of Graduate Medical Education
Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? _____

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____
Department of _____

Is the program accredited by the ACGME: _____

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

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

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

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



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
9. Have you voluntarily surrendered a license to practice medicine or any healing art?
10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
14. Have you voluntarily relinquished medical staff membership?
15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
16. Have you been charged with any criminal offense, other than a minor traffic offense?
17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?
21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

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

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
 2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
 3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
 4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
 5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
 6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
 7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
 8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

1. Training Program

Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: BMC Office of Graduate Medical Education
Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program?

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

Name: Aviva Lee-Parritz Date: 2/12/2013
Designation: Program Director Telephone: (617) 414-5197

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

This certifies that **Natasha R Schimmoeller** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Maxine Kessler Date: 3/25/2013
Designated Official's Title: Director of GME Telephone: (617) 414-5426

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

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

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



**Commonwealth of Massachusetts
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License No.: 252051

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
9. Have you voluntarily surrendered a license to practice medicine or any healing art?
10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
14. Have you voluntarily relinquished medical staff membership?
15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
16. Have you been charged with any criminal offense, other than a minor traffic offense?
17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?
21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?



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 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**



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Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

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Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? _____

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: _____

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

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

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10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
14. Have you voluntarily relinquished medical staff membership?
15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
16. Have you been charged with any criminal offense, other than a minor traffic offense?
17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?
21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

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

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
 2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
 3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
 4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
 5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
 6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
 7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
 8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

1. Training Program

Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: BMC Office of Graduate Medical Education
Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program?

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

Name: Michelle Sia Date: 1/21/2014
Designation: Program Director Telephone: (617) 414-5678

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

This certifies that **Natasha R Schimmoeller** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Maxine Kessler Date: 1/23/2014
Designated Official's Title: Director of GME Telephone: (617) 414-5426

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

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

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



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
9. Have you voluntarily surrendered a license to practice medicine or any healing art?
10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
14. Have you voluntarily relinquished medical staff membership?
15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
16. Have you been charged with any criminal offense, other than a minor traffic offense?
17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?
21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?
22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?
23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?
24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

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

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
 2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
 3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
 4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
 5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
 6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
 7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
 8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

1. Training Program

Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: BMC Office of Graduate Medical Education
Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? _____

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____
Department of _____

Is the program accredited by the ACGME: _____

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

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

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

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



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
9. Have you voluntarily surrendered a license to practice medicine or any healing art?
10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
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12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
14. Have you voluntarily relinquished medical staff membership?
15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
16. Have you been charged with any criminal offense, other than a minor traffic offense?
17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is 'yes', describe the specifics of your condition and any related treatment, including dates and diagnoses.
21. 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 chemicalsubstances, describe the specifics of the treatment, including dates and diagnoses.

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
 2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
 3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
 4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
 5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
 6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
 7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
 8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

1. Training Program

Current Training Program

Facility: Boston Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: BMC Office of Graduate Medical Education
Yawkey Ambulatory Care Center Basement B
Boston
Massachusetts - 02118
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License

Your current Massachusetts Limited License Number is: 252051

5. Other states where you are now licensed to practice medicine

None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program?

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

Name: Michelle Sia Date: 2/27/2015
Designation: Program Director Telephone: (617) 414-5678

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

This certifies that **Natasha R Schimmoeller** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Maxine Kessler Date: 3/12/2015
Designated Official's Title: Director of GME Telephone: (617) 414-5426

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

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

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



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

Physician Name: Natasha R Schimmoeller, M.D.

License No.: 252051

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
9. Have you voluntarily surrendered a license to practice medicine or any healing art?
10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
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16. Have you been charged with any criminal offense, other than a minor traffic offense?
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19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?
20. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is 'yes', describe the specifics of your condition and any related treatment, including dates and diagnoses.
21. 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 chemicalsubstances, describe the specifics of the treatment, including dates and diagnoses.

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
 2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
 3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
 4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
 5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
 6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
 7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
 8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
 9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
 10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
 11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.
- I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Date Received: 1/11/2018
Check #: 202
Check Amount: \$ 10⁰⁰
Initials: EM

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

RECEIVED
JAN 11 2018
Board of Registration in Medicine


WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE
VERIFICATION TO: New Mexico Medical Board
ADDRESS: 2055 S. Pacheco St., Building 400
CITY: Santa Fe STATE: NM ZIP: 87505
PHYSICIAN'S NAME: Natasha Schimmoller
BUSINESS ADDRESS: 1500 7th St #10F
CITY: Sacramento STATE: CA ZIP: 95814
MASSACHUSETTS LICENSE NUMBER: 252051
SIGNATURE OF PHYSICIAN: 
Signed under the penalties of perjury
DATE: 01/09/18

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