Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

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.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope**

RECEIVED
APR 15 1999
Board of Registration in Medicine

Registration No.: 46071 Renewal Date: 06/29/1999 1. Current Status: Active

If you want to change your current status, please indicate below: (Check one).

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

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

3.A) Mailing/Home Address:

JEFFREY M GOOD. M.D.

B) Business Address:
GODDARD MEDICAL ASSOC.PC
1 PEARL STREET
BROCKTON, MA 02401-2800

Home Phone:
Business Phone: (508)586-3600

4. A) Date of Birth: Sex: M
B) SS#:

5. A) Name of Medical School:
University of Barcelona Faculty of Medicine
B) Year Graduated: 1975 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

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

Other Address: Bridgewater Goddard Park Medical Assoc.
City/Town: 110 Liberty ST Brockton State: MA
Zip: 02401 Country: ~~02401~~ Plymouth

Home: (____)_____
Business: (____)_____

Date of Birth: (M/D/Y): __/__/__ Sex : ☐ M ☐ F
SS#: __ __ __ - __ __ - __ __ __ __

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

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

Code: _____ Code: _____

8. Drug License Numbers. if any:
A) Federal (DEA):
B) Massachusetts:

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr: CA
B) States where you previously were licensed to practice
Abbr: MD WI ND NY

Abbr: ___ ___ ___ ___
Abbr: Ca ___ ___ ___

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Last Name: Good Registration Number: 46071

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: 517/✓ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%

Facility Code: ___/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%

If 999, print name(s): _____

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

Name of Insurer: Promutual 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) 20

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

1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 15 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

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 formally 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 surrendered to or suspended, revoked, denied or restricted by 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. 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: 4/7/99

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

PRINT NAME AND NUMBER: Last Name: Good Registration Number: 46071

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: 4/7/99

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

♻

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

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. The Board will charge a fee for each copy.
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

RECEIVED
JUN 0 2 1997
BOARD OF REGISTRATION IN MEDICINE

Registration No.: 46071 Renewal Date: 06/29/97

1. Activity Status: (Check only one) ☑ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

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

3. A) Mailing/Home Address:

JEFFREY M GOOD, M.D.

B) Business Address:
GODDARD MEDICAL ASSOC.PC
1 PEARL STREET
BROCKTON, MA 02401-2800

Home Phone: ---,--- ----
Business Phone: (508)586-3600

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 07/11/80 D) SS#:

5. A) Name of Medical School:
University of Barcelona Faculty of Medicine
B) Year Graduated: 75 C) Degree: MD

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

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

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

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts:

9. A) Other states where you are now licensed to practice
Abbr: CA NY
B) States where you previously were licensed to practice
Abbr: MD WI

Corrections (type or print)

Other Name(s): _____

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

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

Home: (____)_____
Business: (____)_____

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): _____
Lic. Issue Date (M/D/Y): ___/___/___ SS#: _____

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree (MD/DO): _____

Code(s)	Hours Per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___
Abbr: ND ___ NY ___

If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts

LLS

PRINT NAME AND NUMBER: Last Name: Good Registration Number: 46071

10. A. 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).

Facility Code: 517/ (AP) Facility Code: ___/ (AP) Facility Code: ___/ (AP)
Facility Code: ___/ (AP) Facility Code: ___/ (AP) Facility Code: ___/ (AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
If 999, write Name(s): _____

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

Name of Insurer: Pro Mutual

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 Mass. as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 2 0

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

1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 15 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 0 %

PART A

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.

IN THE PAST TWO (2) YEARS:

	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 formally charged with or disciplined for any violation of the 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 surrendered to or suspended, revoked, denied or restricted by 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. Have you completed your CME requirements preceding your renewal date (see instruction booklet)?	☑	☐

☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption

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

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature _____ Date: 5/9/97

PRINT NAME AND NUMBER: Last Name:_____ Registration Number:_____

PART B CONFIDENTIAL MEDICAL INFORMATION

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 provided. Refer to the instruction booklet for additional information and definitions.

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

23. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?

_____

_____

_____

_____

_____

_____

_____

_____

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine?

Treating Organization: _____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

_____

_____

_____

- **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. 62 C, § 49A, I hereby certify that, 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. 112, § 1A, I hereby certify that 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: 5 / 9 / 97

I. PHYSICIAN INFORMATION

JEFFREY	M	GOOD	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 46071
License Status Active

First Issue Date 07/11/80

Hospital Affiliation

1 Pearl St.
Brockton, MA 02401-2800
U.S.A.
(508) 586-3600

Good Samaritan Med Ctr-Goddard Campus

Make address corrections here:

GODDARD MEDICAL ASSOC.
ONE PEARL STREET
BROCKTON, MA 02401-2800

Make any corrections to above here:

add: Good Samaritan Medical Center - Cushing Campus

Insurance Plan Affiliation:

All Blue Cross Products
Harvard/Pilgrim
Admar
CIGNA
PHCS
Brighton Marine

Licenses Held in Other States:

CA
NY

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No
Accept Medicaid? ☑ Yes ☐ No

II. EDUCATION & TRAINING

University of Barcelona Faculty of Medicine	MD	75	
Medical School	*Degree*	*Date*	

Make corrections here

Nassau Hospital (SUNNY Stony Brook Medical School, Mineola, NY (Intern)	7/1975	End 6/1976
Residency Program(s)	*Start*	
St. Joseph Hospital (Loyola Univ. Medical School) Chicago, IL (Ob/Gyn)	7/1976	End 6/1977
Residency Program(s)	*Start*	
Mt. Sinai, Milwaakee, WI (Ob/GYN)	7/1977	End 6/1980
Residency Program(s)	*Start*	

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

6/19/95 JP

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
46071	ACTIVE	$250.00	06/29/95	$25.00

Mailing Address:
JEFFREY M GOOD, M.D.

Correction of Mailing Address

Address (Mailing): _____
_____
City/Town: _____
State: _____
Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- **Add late fee if necessary.**
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.

For Office Use Only
M.R. _____
Pr. _____
Bd.D.S. _____

RECEIVED
JUN 16 1995
BOARD OF REGISTRATION IN MEDICINE

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. Business Address:
1 PEARL STREET
BROCKTON, MA 02401

3. Date of Birth: Sex: M
Lic. Issue Date: 07/11/80 SS#:

Home Phone Business Phone
(508)586-3600

4. Name of Medical School:
University of Barcelona Faculty of Medicine
Year Graduated: 75 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): CA NY
b) States where you previously were licensed to practice (Abbr): MD WI

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

Code	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
Code: OG Code:

8. Drug license number(s), if any:
a) Federal (DEA)
b) Massachusetts

Corrections of Pre-Printed Information

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

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____
Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____
Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Physician Last Name: Good Registration Number: 46071

10. a) Current health care facility(ies) 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 facilities where you have admitting privileges (AP).

Facility Code: 1 0 1 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier ✓ (b) Letter of Credit ___ If applicable, check one.
List Insurer: Pco Mutual

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___
State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No ✓ (Check one)

13. a) What is your principal work setting? (See Table 4) 2 0

b) Care of patients in Massachusetts (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 25 hrs/wk
ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 15 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 0 %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which 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 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 by a patient, 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 formally charged with or disciplined for any violation of the 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 surrendered to or suspended, revoked, denied or restricted by 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 or imposed a surcharge 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. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested ___
No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, 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. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: 5/31/95

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
46071	ACTIVE	$250.00	06/29/93	$25.00

Mailing Address:
JEFFREY M GOOD, M.D.

Correction of Mailing Address:
Address (Mailing): _____
_____
City/Town: _____
State: _____
Country Code (See Table 1): _____

Directions: Staple check to bottom of form. Add late fee if necessary.
- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.
- Before proceeding, please read the instruction booklet. Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. FP JUN 10 1993
Pr. JUN 10 1993
Bk/D.E. 6-10-93 CH

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. a) Address (Home):

   b) Address (Business):
   1 PEARL STREET
   BROCKTON, MA 02401

3. Date of Birth: Sex: M
   Lic. Issue Date: 07/11/80 SS#:
   Telephone Number:
   Home: Business: (508)586-3600

4. Name of Medical School:
   University of Barcelona Faculty of Medicine
   Year Graduated: 75 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): CA NY
   b) States where you previously were licensed to practice (Abbr): MD WI

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.
06G	40
	0

   Obstetrics and Gynecology

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: 06 Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

8. Drug License Number(s), if any: a) Federal (DEA)
   b) State (MA)

9. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested _____
   You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): _____
City/Town: _____
Country Code: _____ If 999 print Country: _____

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____
Telephone Number:
Home: ( ) Business: ( )

Full Name of Medical School: _____
_____
Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	
___ ___ ___	

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

Federal (DEA): _____
State (MA): _____

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Good Registration Number: 46071

10. **Activity Status:** I am applying to be registered with the following status: Active ✓ Inactive ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.

List Insurer: JUA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am

(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___

(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 3 1 1 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 1 0 1 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes___ No ✓ (Check one)

14. a) What is your principal work setting? (See Table 5) 3 0

b) Care of patients in Massachusetts (MA) (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in MA? 25 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 15 hrs/wk in MA

Questions 15 through 23 refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

- **Pursuant to G.L. c. 62C, sec. 49A, I hereby certify under the penalties of perjury that, 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 country.**

- **I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.**

- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: [signature] Date: 1 1

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1991-1993 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date
42071	ACTIVE	$150	06/29/91

Dr. JEFFREY M GOOD

For Office Use Only

M.R. ____ ___/___/___
Pr. ____ ___/___/___
BI ____ ___/___/___
Ch. ENTERED JUN 4 1991
D.E. ____ ___/___/___

Directions:

- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:

I am applying to be registered with the following status: Active ✓ Inactive ____

I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information	***Corrections of Pre-Printed Information***
1. Other Name(s), if any, under which you were licensed:	Name:
2. a) Address (Home):	Address: City/Town State: Zip: Country Code: (If 999 write Country):
2. b) Address (Business): 1 PEARL STREET BROCKTON, MA 02401-	Address: City/Town: State: Zip: Country Code: (if 999, write Country):
3. Date of Birth Sex: M Lic. Issue Date 07/11/80 SSN # Telephone Number: Home (508)238-4466 Business (508)586-3600	Date of Birth (M/D/Y): ___/___/___ Sex (M/F): Lic. Issue Date(M/D/Y): ___/___/___ SSN #: Home: (___)___ Business: (___)___
4. Medical School Code SPA01 Year Graduated 75 Degree: MD Name of School: University of Barcelona Faculty of Medicine	School Code: Year Graduated: Degree (MD/DO): If 99999, write School:
5. a) Other States where you are now licensed to practice (*Abbr*) CA NY b) States where you previously were licensed to practice (*Abbr*) MD WI	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
6. Specialty Code(s) *(See Table 3)*: Code: OBG Hours per Week in Mass.: 0 Obstetrics and Gynecology 0	Code: CBG Hours per Week in Mass.: 40 ___ ___ If OS, write specialty:
7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes: Code: OG Board of Obstetrics and Gynecology Code:	Code: Code:

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA)____ b) How many DEA nos. do you have? ____
c) State (MA) #M____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES ✓ Waiver Requested____
(You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See Instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*

[For Office Use Only: Waiver Granted____ Date:___/___/___]

FILL IN NAME AND NUMBER:

Physician Last Name: Good Registration No.: 46071

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT_____. If applicable, check one.

List Insurer: JHA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

(State how otherwise exampt):_____

11. Current Hospital Affiliations *(Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).*

Facility Code: 101/_(AP) Facility Code: ___/_(AP) Facility Code: ___/_(AP)

Facility Code: 311/_(AP) Facility Code: ___/_(AP) Facility Code: ___/_(AP)

If 999, write Name(s):_____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code:___ Facility Code:___ Facility Code:___ Facility Code:___

If 999, write Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No ✓ (Check one.)

b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program?_____hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 25 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 15 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? *(See Table 6)* 10

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A.
Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?.....		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?.....		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national state or local)?.....		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?.....		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?.....		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?.....		

Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.

I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.

Signature:_____ Date 4/24/91

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

February 4, 1993

Jeffrey M. Good, M.D.

Re: Complaint regarding
3 malpractice actions
Docket number 86 02101-GO

Dear Dr. Good:

The Complaint Committee reviewed the matter of three prior malpractice complaints pending against you (Walsh, Navis and Duffy) and voted not to pursue these matters. This complaint was therefore dismissed. ..

Yours very truly,

James J. Barrett
Complaint Counsel

BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC. NUMBER, OPTIONAL

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☑
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD	1	46071	$100	100	06	29	87	

NOTE! **THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.**

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

JEFFREY M GOOD

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: Jeffrey M. Good
2. Date of Birth: MONTH DAY YEAR
3. Medical School: University of Barcelona M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: Spain
5. Date of Graduation: 1975
6. American Specialty Board Certified? ☑ (Check if yes.)
   Which Boards? OB-GYN
7. Principal Specialty(ies): OB-GYN
8. Principal work setting: HMO/multispecialty clinic
9. Home address:
10. Principal business address: 1 Earl St
    Brockton, Ma 02401
11. List all hospitals at which you have currently effective privileges: Goddard Memorial Hospital, Cardinal Cushing Hosp
12. List all hospitals at which you have held privileges in the past 20 years: Goddard Memorial Hospital, Cardinal Cushing Hosp
13. States other than Massachusetts in which you are presently licensed to practice: Calif, New York, Wisc, North Dakota
14. List any other states where you were previously licensed to practice:

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: 100 hours of CME all category 1
26. I am an active ☑ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.
PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.
PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

SIGNATURE

DATE: May 1, 1987

(See Reverse Side)

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

067934

Board Use Only:

Registration No.	Status	Fee	Renewal Date
		$150	

APR 1989 RECEIVED

M.R. Pr. Bk. Ch. D.E. FI.

Important:

- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--***it is not adequate to state that the Board already has the information.**
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) Good (FIRST:) Jeffrey (M.I.:) M

1. b) Other Name(s), if any, that you were ever licensed under:

2. a) Address (Mailing): same as above

2. b) Address (Home):

2. c) Address (Business): one Pearl St Goddard Medical Associates
Brockton, Ma 02401

2. d) Telephone (Business): (508) 586-3600 Extension 2790 2. e) Telephone (Home) *(Optional)*: (

3. Date of Birth (MO/DA/YR): 4. Sex: MALE ✓ FEMALE 5. Social Security No. *(Optional)*:

6. a) Medical School Code *(See Table 1)*: SPAC1 *If 99999, write* Name:

6. b) Year Graduated: 1975 6. c) Degree: M.D. ✓ D.O.

6. d) Country: U.S. Canada Code if Other *(See Table 2)*: 155 *If 999, write* Name:

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

10 Hospital	20 %	15 Private Office	%	20 Partnership/Group Practice	40 %
25 Clinic	%	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	40 %	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

8. Professional Activity *(Circle and indicate Percent(%) of Professional Time)*:

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	100 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 7/11/80
30 Administrative Activities	%	40 Medical Teaching	%	
50 Medical Research	%	99 Other	%	

9. Specialty Code *(See Table 3)*: 136 Percent of Practice Time: 100 % Specialty Code: Percent of Practice Time: %
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) Y *10. b) If YES, circle which Board(s):*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	OG	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*

Facility Code: 101 75 % Facility Code: % Facility Code: %
Facility Code: 304 25 % Facility Code: % Facility Code: %

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: Facility Code: Facility Code: Facility Code: Facility Code:

If 999, write Name(s):

I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) attached pages--is true.

Signature Date

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

Fill in name and number. **Physician Last Name:** Good **Registration No.:** 46071

12. a) Other States where you are now licensed to practice (*Abbreviate*): NY CA ___ ___ ___ ___

12. b) States where you previously were licensed to practice (*Abbreviate*): ND Wi ___ ___ ___ ___

13. I am applying to be registered with the following status: ACTIVE ✓ INACTIVE___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 102 hrs., Category II: ____hrs., (Risk-Management: 27 hrs.); Residency Program in:_____;
Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer: JHA Institution Issuing Letter of Credit:_____
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___ OTHERWISE EXEMPTED___ *(State how)*_____

14. c) Percent of Practice Time in Massachusetts: 100 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ___ ___ ___		

Additional Information Related to Questions 18 through 24 *If you answered YES to any of Questions 18--24 provide the following information where applicable.*

Privileges to Prescribe Controlled Substances *Attach additional sheets (with same format) where necessary.*
Type of Restriction:_____ Date:___/___/___
Circumstances of restriction:_____

Withdrawal or Denial of License *Attach additional sheets (with same format) where necessary.*
State:_____ Year:_____ Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated):_____

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary.*
Treating Organization:_____ Telephone:(___)___-____
Address:_____
Person Responsible for Treatment:_____
Type of Condition and Treatment:_____
Dates of Illness/Dependency:___/___/___ to :___/___/___ Dates of Treatment:___/___/___ to :___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary.*
Organization:_____
Date:___/___/___ Action:_____
Circumstances leading to loss of certification or denial of recertification:_____

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

007834

Board Use Only:

Registration No.	Status	Fee	Renewal Date
46071	1	$150	06/[illegible]

JEFFREY M GOOD

APR 1989 RECEIVED

M.R. Pr. Bk. Ch. D.E. Fl.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely–***It is not adequate to state that the Board already has the information.**
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records–you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) Good (FIRST:) Jeffrey (M.I.:) M

1. b) Other Name(s), if any, that you were ever licensed under:

2. a) Address (Mailing): same as above

2. b) Address (Home):

2. c) Address (Business): one Pearl St Goddard Medical Associates
Brockton, Ma 02401

2. d) Telephone (Business): (508) 586-3400 Extension 2790 2. e) Telephone (Home) *(Optional)*:

3. Date of Birth (MO/DA/YR): 4. Sex: MALE ✓ FEMALE ___ 5. Social Security No. *(Optional)*:

6. a) Medical School Code *(See Table 1)*: 5 P A O 1 *If 99999, write* Name:

6. b) Year Graduated: 1975 6. c) Degree: M.D. ✓ D.O. ___

6. d) Country: U.S. ___ Canada ___ Code if Other *(See Table 2)*: 1 5 5 *If 999, write* Name:

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

10 Hospital	20 %	15 Private Office	___%	20 Partnership/Group Practice	40 %
25 Clinic	___%	30 Mental Health Center	___%	35 Nursing Home	___%
40 HMO Facility	40 %	45 Educational Institution	___%	50 Medical Society	___%
55 Government Facility	___%	60 Plant/Commercial Setting	___%	99 Other	___%

8. Professional Activity *(Circle and Indicate Percent(%) of Professional Time)*:

10 Resident or Fellow	___%	20 Practice Involving Direct Patient Care	100 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 7/11/80
30 Administrative Activities	___%	40 Medical Teaching	___%	
50 Medical Research	___%	99 Other	___%	

9. Specialty Code *(See Table 3)*: O B G Percent of Practice Time: 100 % Specialty Code: ___ Percent of Practice Time: ___%
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) Y *10. b) If YES, circle which Board(s)*:

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	(OG)	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*

Facility Code: 1 0 1 95 %	Facility Code: ___ ___ ___%	Facility Code: ___ ___ ___%
Facility Code: 3 0 4 5 %	Facility Code: ___ ___ ___%	Facility Code: ___ ___ ___%

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write Name(s):

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) ___ attached pages--is true.

Signature: [signature] *(see reverse side)* Date: 4/6/89

Fill in name and number. **Physician Last Name:** Good **Registration No.:** 46071

12. a) Other States where you are now licensed to practice *(Abbreviate)*: NY CA ___ ___ ___ ___

12. b) States where you previously were licensed to practice *(Abbreviate)*: ND WI ___ ___ ___ ___

13. I am applying to be registered with the following status: ACTIVE ✓ *INACTIVE ___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 102 hrs., Category II: ____hrs., (Risk-Management: 27 hrs.); Residency Program In: _____;
Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer: JHA Institution Issuing Letter of Credit: _____
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___ OTHERWISE EXEMPTED___ *(State how)* _____

14. c) Percent of Practice Time in Massachusetts: 100 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached. **Yes** **No**

15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? .....

16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?.....

17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? .....

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section. **Yes** **No**

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

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?.....

23. Have you, for any reason, lost American Specialty Board Certification?.....

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ___ ___ ___ .....

Additional Information Related to Questions 18 through 24 *If you answered YES to any of Questions 18--24 provide the following information where applicable.*

Privileges to Prescribe Controlled Substances *Attach additional sheets (with same format) where necessary.*
Type of Restriction: _____ Date: ___/___/___
Circumstances of restriction: _____

Withdrawal or Denial of License *Attach additional sheets (with same format) where necessary.*
State: _____ Year: _____ Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated): _____

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary.*
Treating Organization: _____ Telephone: (___) ___-____
Address: _____
Person Responsible for Treatment: _____
Type of Condition and Treatment: _____
Dates of Illness/Dependency: ___/___/___ to : ___/___/___ Dates of Treatment: ___/___/___ to : ___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary.*
Organization: _____
Date: ___/___/___ Action: _____
Circumstances leading to loss of certification or denial of recertification: _____

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 6-1-01

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 *4 weeks* before your renewal date.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

RECEIVED JUN - 1 2001 Board of Registration in Medicine

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

1. Current Status: Active Registration No.: 46071 Renewal Date: 06/29/2001

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:
JEFFREY M GOOD

B) Home Address:

Home Phone:

Business Phone: 508-894-0400

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: M

c) SS#:

5. a) Name of Medical School:
University of Barcelona Faculty of Medicine

b) Year Graduated: 1975 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology
	0	

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG 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.)
___ ___ ___ ___ ___ ___ ___ ___
MD WI ND NY CA

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: 118/✓ (AP) 99 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: 22/___ (AP) 1 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Good LICENSE NUMBER: 460716

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Promutual 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) 2 0
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 15 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

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: 5/11/01

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.

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: 5 / 11 / 01

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.: 46071 Renewal Date: 06/29/2003

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:

A) Mailing/Business Address:

3. JEFFREY M GOOD

B) Home Address:

Home Phone:

Business Phone:

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: (508) 844-0328

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: M
c) SS#:

5. a) Name of Medical School: University of Barcelona Faculty of Medicine
b) Year Graduated: 1975 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

0

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG 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.) MD WI ND NY CA

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: 1 1 8 / ✓ (AP) 99 % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %
Facility Code: 3 2 / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: Good LICENSE NUMBER: 46071

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

Insurer's name. (Required): Promutual Policy dates: From: 3/31/03 To: 3/31/04

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) 2 0 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 15 hrs/wk B) outpatient care 25 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: ____/____/____

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: Good LICENSE NUMBER: 46071

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

Insurer's name. (Required): Prumutual Policy dates: From: 3/31/03 To: 3/31/04

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) 2 0 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 15 hrs/wk B) outpatient care 15 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: ___/___/___

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: _____ License Number: _____

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: 5/9/03

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

July 14, 1989

Dear Ms. :

The Board's Complaint Committee has thoroughly reviewed the complaint filed by you against Dr. Jeffrey Good and has decided that a letter of concern is the most appropriate response to your complaint.

The Board's authority to discipline a physician is limited by statute to conduct which calls into question a physician's competence to practice medicine, such as gross misconduct, gross negligence, and repeated acts of negligence. Upon reviewing your complaint the committee has determined that your complaint does not rise to the level required for disciplinary action.

The Committee is, however, quite concerned with the communication problems which developed between you and Dr. Good and has expressed its concerns to him. The Committee also conveys their sympathy to you for your loss, and for the pain, fear, and anxiety you experienced during your operative procedure. Thank you very much for bringing this matter to the Board's attention. If you have questions, please do not hesitate to contact me at 727-1788.

Sincerely,

Melissa A. White
Investigative Unit

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

July 14, 1989

Dr. Jeffrey Good
Goddard Medical Associates
1 Pearl Street
Brockton, MA 02401

Dear Dr. Good:

The Complaint Committee at the Board of Registration has thoroughly reviewed the complaint filed against you by Mrs. . The Committee has decided to dismiss this complaint as there appears to be no evidence of conduct which calls into question your competence to practice medicine.

The Committee is, however, quite concerned with the lack of documentation of the medication you alleged to have given Mrs. prior to and during her operative procedure. There is no evidence of this medication in her chart. The Committee is also concerned with the communication problems which developed between yourself and your patient. Mrs. 's description of the events which occurred illustrate the level of anxiety and fear she experienced around this procedure. The Committee recommends that Mrs. 's complaint serve as constructive criticism and that serious attention be paid to your communication skills in order to avoid this situation in the future.

If you have any questions, please do not hesitate to contact me at 727-1788.

Sincerely,

Melissa A. White
Investigative Unit

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

January 25, 1989

Dr. Jeffrey Good
Goddard Medical Associates
1 Pearl Street
Brockton, MA 02401

Dear Dr. Good:

Enclosed you will find a copy of ' medical release authorization. Please forward me a copy of all of her medical records so that the Board may properly consider Ms. ' complaint which you received a copy of and to which you responded to me on December 8, 1988.

Please be advised that 243 CMR 2.07 (12) requires that you respond within thirty (30) days' receipt of this letter.

Thank you very much for your prompt attention to this matter.

Sincerely,

Julie M. Conway
Investigator

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

December 14, 1988

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

RE: Dr. Jeffrey Good

Dear Ms. :

I have received a response from Dr. Good which details his usual practices in performing D&C procedures in his office. After consultation with several investigative attorneys here at the Board, it is not uncommon for doctors to preform D&C procedures in the office. Dr. Good also informed me of this fact.

The Board realizes that not all patients are appropriate candidates for this office procedure. In order for the Board to further its investigation I need to subpoena your medical records from Dr. Good. I have enclosed a medical release form for you to sign and send back to me. This is a routine procedure which will enable the Board to specifically address Dr. Good with the substantive issues set forth in your complaint.

If you have any questions please do not hesitate to call me at 727-1788. Also I spoke with your husband on November 21, 1988 at which time he stated he wished to make an ammendment to your original complaint. If you or your husband wish to ammend your complaint, please forward the ammendment to me as soon as possible.

Thank you for your patience. I will continue to keep you informed of any developments as I continue the investigation.

Sincerely,

Julie M. Conway

Julie M. Conway
Investigator

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

November 14, 1988

Dear Ms. :

Thank you for your letter of October 5, 1988 regarding Dr. Jeffrey Good. I have recently been assigned to investigate this matter. I have notified Dr. Good of your allegations and expect to hear from him within thirty (30) days.

The Board will continue to notify you of any developments throughout the course of its investigation. If you have any questions or additional information you believe may be helpful please do not hesitiate to contact me at 727-1788.

Sincerely,

Julie Conway
Investigative Unit

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

JC

88-462

October 21, 1988

Re: Jeffrey Good, M.D.
Docket No. 88-462

Dear Mr. :

The Board of Registration in Medicine is in receipt of your letter of complaint.

This matter will be assigned to a staff member for investigation. The staff member assigned to your case will contact you within sixty days if additional information is needed. Should you have any additional information pertaining to this complaint please contact the Investigative Unit at the above address. All correspondence should include the name of the physician and docket number which appears above.

Thank you for bringing this matter to the Board's attention.

Very truly yours,

Peter Clark
Chief, Disciplinary Unit

PC/zm

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

November 15, 1988

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

Jeffrey Good, M.D.
Goddard Medical Associates
1 Pearl Street
Brockton, MA 02401

Dear Dr. Good:

The Board of Registration in Medicine has recently received the enclosed letter from Ms. , of Stoughton, MA.

The Board is obligated to investigate matters relato the proper practice of medicine. In compliance with this mandate the Board seeks all information pertaining to a complaint or inquiry. This investigation enables the Board to make a preliminary determination as to whether a matter warrants further action.

In order to allow us to fully understand the circumstances surrounding the enclosed letter, the Board requests that you respond to the enclosed by addressing the substantive issues set forth in Ms. Simms' letter. Please be advised that 243 CMR 2.07 (12) requires that you respond within thirty (30) days' receipt of this letter.

Thank you very much for your prompt attention to this matter. Please direct your response and any questions to Julie Conway, Investigative Unit.

Sincerely,

Carolyn Hartmann
Investigative Attorney

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

October 5, 1988

Ms. Mary Kelley
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Dear Ms. Kelley:

I am writing to you in complaint of Dr. Jeffey Goode, Goddard Medical Associates, N. Pearl St., Brockton, MA who was a referral for a procedure from my then doctor (, Goodard Medical) and which was performed on September 1, 1988.

First, I must state that I am not in the habit of complaining about the medical profession and I feel I have been fortunate in receiving excellent care since birth. However, I must state that Dr. Goode did not give me the care I should have received that day. The procedure I had was D&C and I had been bleeding for two days prior to the procedure (Dr. was aware of that). On the morning of September 1st I had to undergo an Ultrasound which confirmed that the baby had not formed past 8 weeks old. Dr. then performed and internal and sure enough my cervix had started to dilate. She did not recommend that I miscarry myself as I was 12 weeks along and she felt it would have been to much for me. She wanted to refer me to Dr. Goode for a D&C procedure.

Enter Dr. Goode whom did not wish me to go to the Goddard Memorial to be put under general anthesia (Dr. suggested I could have that option) but wanted to perform the procedure there. I assumed the other option which Dr. told me was a local anthesia (I knew I would be awake) was what Dr. Goode was referring to. Dr. Goode asked me before he started if I wanted any (and I forget the name of the drug he said) I again assumed it was anthesia and I told him that he was the doctor and that I would leave it up to his judgment as I had never undergone a D&C before and did not know the amount of discomfort I would feel. He decided to give me a spray local and started to put in a metal device to dilate me further. At this point I started screaming because the pain was excruciating.

Dr. Goode did not appreciate my screaming and yelled at me that he hadn't done anything to me yet. I kept crying and telling him it hurt badly. He stopped with the metal dilator and put another type of dilator in that expands over several hours and informed me he would proceed that afternoon at three o'clock.

At three o'clock we (my husband was with me throughout the whole day) went back to Goddard Medical and Dr. Goode gave me 5mg of Valium and some Motrin (I can't remember the dosage). I have had Valium before for a back injury and knew that 5mg was not very much. I then assumed that he was giving me the valium to relax me for a needle of local anthesia and I asked my husband to confirm that with him. My husband came back in the room and told me Dr. Goode stated that the 5mg was sufficient to calm me down. Dr. Goode came into the room a few minutes later and asked me if I was calm enough and relaxed, I stated that I was not calm and was very nervous. He then told me and I quote "think of this as a dental procedure". And he proceeded with the D&C (without any anthesia).

I can't tell you what it felt like, but if hell is a place (which I believe it is) I certainly do not want to go. My husband had to hold me down on the table I was screaming so badly and trying to get away from him. He was yelling at me to not move and lie still. I don't know how long the procedure lasted, but it felt like an hour to me. I assure you I have never experienced anything like it in my entire life - dental pain is nothing compared to this. After the procedure ended my blood pressure had dropped so much that the nurses were afraid I was going into shock. After about a half an hour I was better and wanted to get dressed to get out of there. I was told by a nurse that Dr. Goode wised to see me in his office. All of the nurses were out at his work area I noticed because there were about 10 of them and they were all looking at me and a few of them asked how I was. At that point I was walking doubled over in pain and as I got near Dr. Goode he told me not to limp as he didn't operate on my leg. (Some of the statements he made to me went over my head because I really was in so much pain and that was all I was thinking about). I then started apologizing to him for scraming at him during the procedure. He went on to tell us that he wasn't sure if the procedure worked. At that point my husband spoke up and asked why he thought it might not have worked and he stated it was because of the way I was.

He also stated that I might have to come back again if I was bleeding heavily because that was a sure sign that he didn't get it all.

I can safely say that I am doing really well now (I was checked by a former doctor who is not affiliated in any way with Goddard Medical Associates). I asked the doctor who checked me about that procedure being done that way and he stated that he had never heard of it being done like that. He further said that he was sorry I had to go through such needless suffering and doctors he is affiliated with always put there patients under general anthesia.

I know I am not the only woman who has miscarried, however I am the only one of the women I know to have had that procedure done that way and looking back on that catastrophe I feel that I was cruelly treated. Being upset to begin with because you must face that you have lost a child that you wanted very badly is such an emotional factor to deal with, but having to go through such agony on top of that is sheer hell. I hope Ms. Kelley that in some way you can look into this doctor and stop him from treating other women, in a similar situation like mine, the same way he treated me.

Should you need me for any further information, please don't hestitate to call me, (I am usually home before 8:30 a.m. or after 5:30 p.m. or if you wish to speak with me at work my number here is . Please let me know what you can do or can't do to help.

Thank you for your time and kind consideration.

Very truly yours,

GODDARD MEDICAL ASSOCIATES, P.C.
ONE PEARL STREET • BROCKTON, MASSACHUSETTS 02401 • PHONE (617) 586-3600

December 8, 1988

CERTIFIED MAIL, RETURN
RECEIPT REQUESTED

Ms. Julie Conway
Investigative Unit
Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, MA 02111

RE: Complaint Lodged By

Dear Ms. Conway:

I am responding to Ms. Hartman's letter of November 15, 1988, regarding a letter received by the Board of Registration in Medicine from Ms. of .

As you can see from Ms. ' letter, she was referred to me on September 1, 1988 by her family practitioner Dr. , with a diagnosis of incomplete abortion. Because Ms. ' body had not spontaneously discharged the products of conception (or, to quote Ms. , she did not "miscarry herself"), a D&C (dilatation and curettage) was required. It appears from Ms. ' letter that Dr. explained to her that a D&C could be performed in a hospital under general anesthesia or as an in-office procedure during which the patient is awake.

So that you can best understand my recommendations to and treatment of Ms. and thereby understand why Ms. ' claims that she was "cruelly treated" are without merit, I would first like to explain my philosophies and then my office procedures and practices with regard to the evaluation and treatment of a patient presenting to me with a diagnosis of incomplete abortion.

It is my opinion that hospital admission for a D&C is warranted and medically indicated if there is evidence of infection or if the patient is hemodynamically unstable. For the majority of other patients, however, I feel that the psychological impact of hospitalization for a procedure that takes less than two minutes is unwarranted. The couple that miscarries goes through a grieving process and I feel very strongly that they need each other's support during this period of time, support which cannot be shared if the procedure is performed in a hospital. When a patient such as Ms. undergoes the procedure in the hospital, she enters and is admitted to the hospital in the morning, but she probably will be scheduled for surgery at the end of the day because she is hemodynamically stable and the

procedure is not an emergency. After going through the admissions procedure, she would be sent to a room to wait until she was called to surgery. She would then be transported into an operating room, subjected to the risks inherent in spinal or general anesthesia and would be separated from her support person throughout the procedure. After the procedure is terminated, she would be transferred to the Recovery Room for approximately two hours and then sent back to her room. All of these unfamiliar surroundings can be psychologically devastating to a person who is going through the grieving process. On the other hand, if that separation can be eliminated, the couple can support one another emotionally during this most trying period of time. Accordingly, I feel very strongly about performing this routine procedure in an out-patient setting where the patient is never separated from her support person and my general practice in treating any patient in this situation for the past eight years that I have been in practice is to recommend an in-office D&C under local anesthesia with the use of a Laminaria (see below) if dilatation of the cervix is necessary.

Thus, my general practice with a patient such as Ms. is as follows. After the patient is examined and diagnosis is confirmed, I explain to the patient that she will require a D&C. I explain that this procedure is routinely performed as an out-patient procedure by most obstetricians and explain my reasons for selecting an out-patient setting rather than hospitalization to perform this procedure. Specifically, I explain that there are two reasons for my recommendations: (1) the psychological impact of hospitalization and (2) the potential risks associated with spinal and general anesthesia which I believe outweigh any benefits. My explanation includes the fact that if the patient's cervix is sufficiently dilated to easily admit the #8 suction tip curette, I will proceed at that point with a curettage. If dilatation is necessary, I will use a Laminaria (a little stick-like device made of a hydrophilic substance) which passively dilates the cervix over a period of hours, eliminates the necessity for instrumental dilatation of the cervix and therefore less damage and less discomfort can be expected. I explain that there will be <u>some</u> discomfort and the patient is offered additional sedation, an analgesia with the use of Valium and Motrin. I then perform the D&C. After the procedure is completed, I meet with the patient and her support person, give them some written materials, and discuss with them any questions they have and the post-operative instuctions contained in the materials. As part of our discussion, I routinely explain that due to the intrinsic nature of the procedure (i.e. it is done by feel rather than by sight), we can never know immediately if the procedure has been complete and it is therefore very important that they follow the instructions and watch for various signs and symptoms which might indicate a problem.

Other than my records and Ms. ' letter, I have no independent recollection of treating Ms. on September 1, 1988. From reading both my records and Ms. ' letter, however, I know that I followed my general practice. Specifically, a D&C as an out-patient procedure under local anesthesia was recommended. An antiseptic solution was sprayed on the patient's perineum and a bivalve speculum was placed into the vagina thus exposing the cervix. Since her cervix had not spontaneously dilated sufficiently to admit easily a #8 suction tip curette, a laminaria tent was placed into the endocervical canal which was designed to produce non-mechanical cervical dilatation over a period of hours. Later that afternoon, the patient returned to my office and underwent a suction curettage after being premedicated with 5 mg. of Valium and 800 mg. of Motrin. The patient received 20 cc. of Nesacaine pericervical block prior to the curettage. As is my general practice, the procedure took approximately two minutes. After the procedure was terminated, I spoke with Ms. Simms and her husband in my office, giving them my routine post D&C instructions as described above.

After receiving this letter of complaint, I spoke to my nurse in an attempt to refresh my recollection about this patient. My nurse remembered Ms. and remembered that Ms. was emotionally devastated with the diagnosis of incomplete abortion. My nurse reminded me that I had asked her to stay with Ms. and also had a nurse practitioner with us to provide additional emotional support to my patient. Neither of us recall, nor do my records indicate, the drop in blood pressure which Ms. describes in her letter. I am confident however, that no one notified me that her blood pressure had dangerously dropped and further that Ms. was not in shock as no intravenous fluids or blood replacement was required or administered.

I had been performing this procedure as described in the proceeding paragraphs for the past eight years and this is the first complaint that I am aware of. I have had patients tell me that they were grateful that the procedure was performed in this manner and that they did not have to cope with the ordeal associated with hospitalization. In formulating a plan of management for a patient with any given problem, I take into consideration how I would want a family member treated given a similar situation. In this specific situation, I speak not only as a physician, but also as a father who underwent the experience of miscarriage in August, 1983. At that time, my wife underwent the same in-office procedure performed on Ms. ; my wife and I were very grateful that we were able to be together to support each other during that period of time and were not separated by an impersonal hospital procedure.

In fact, my description of the discomfort as analogous to "dental pain", which Ms. cites in her letter, is a direct quote from my wife describing her own D&C. Thus, Ms. was treated exactly as my wife was managed.

I believe that all inquiries from the Board of Registration in Medicine and all patient complaints deserve the most serious attention, as has been given to this patient's complaint. However, as explained above, I believe that the allegations made by Ms. are without merit and arise not so much from her physical experience but rather from the fact that she had lost a child she "wanted very badly" which colored her perceptions of discomfort. Nonetheless, regardless of my beliefs, it is clear that my patient is unhappy and I would appreciate it if you would kindly convey to her that I am very sorry that she experienced discomfort during the procedure. It was certainly not my intention to cause her any pain and I am very glad to learn that she is "doing really well now". Further, it was never my intention to upset, embarrass or offend her and I apologize if anything I said or the tone which I may have used (i.e. my alleged comment about not having operated on her leg) was so construed.

I thank the Board for this opportunity to respond to the allegations in Ms. ' letter. I hope that I have addressed all of the Board's concerns; if you have any further questions and if I can provide you with any further information, please feel free to contact me.

Sincerely,

Jeffrey M. Good, M.D.

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

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

RELEASE OF MEDICAL RECORDS AUTHORIZATION

NAME OF PATIENT:

ADDRESS:

DATE OF BIRTH:

I HEREBY AUTHORIZE THE FOLLOWING PHYSICIAN OR INSTITUTION TO RELEASE MY MEDICAL RECORDS TO THE BOARD OF REGISTRATION IN MEDICINE, 10 WEST STREET, 2ND FLOOR, BOSTON, MASSACHUSETTS 02111.

NAME OF A PHYSICIAN OR INSTITUTION:
Dr. Jeffrey Good

ADDRESS:
1 Pearl Street
Brockton, MA 02401

DATE OF SERVICES RENDERED:

DEC 1988 RECEIVED

SIGNATURE OF PATIENT (or Legal Representative):

DATE: Dec. 19th, 1988

SIGNATURE OF WITNESS: Julie L Cooney

DATE: 12-19-88

Massachusetts Physician Renewal Application

Physician Name: JEFFREY M GOOD **License No.:** 46071

PART A

1) Current Status: Active **Renewal Due Date:** 06/01/2005 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one). (*See Renewal Instructions, page 3.*)

☑ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

Please make corrections (print)

2a) MAILING ADDRESS

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

BRIDGEWATER GODDARD PARK
MED. ASSOC.110 LIBERTY
BROCKTON, MA 02401-0000

Phone: (508)894-0328

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Business address cannot be a Post Office Box

RECEIVED
APR 29 2005
Board of Registration in Medicine

RECEIVED
MAY 10 2005
BOARD OF REGISTRATION IN MEDICINE

3) E-mail Address: _____

4) Fax Number: 508-894-0332

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. *(See enclosed instructions and Renewal Instructions, page 4.)*

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Correct?**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☑	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: JEFFREY M GOOD **License No.: 46071**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	____ ____ ____ ____ ____ ____ ____ ____
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	MD WI ND NY CA ____ ____ ____

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*

Principal Work Setting: Partnership or Group Practice Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 25

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Brockton Hospital	☐	Active		15 (3 times per month 24 hour call)
Morton Hospital & Medical Center	☐	courtesy		0
	☐			
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 15 hrs/wk Change to: ____ hrs/wk

b) outpatient care 15 hrs/wk Change to: 25 hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

My medical liability insurance is provided through: **(check one)**

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 3/31/05 To 3/31/06 *(required)*

☐ **Letter of Credit subject to Board approval** ***(attach a copy)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: JEFFREY M GOOD **License No.: 46071**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)*
If Yes, please complete Form PCA-O "Office Based Surgery"

In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
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, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☑ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application.
(See Renewal Instructions, page 9.)

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 (see Renewal Instructions, page 9.)

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.

Under penalties of perjury, I declare that I have examined this 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.

Signature: _____ Date: 4/15/05

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: JEFFREY M GOOD License No.: 46071

PHYSICIAN PROFILE

☑ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

CERTIFICATIONS

1) 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.

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

3) 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.

4) 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.

5) 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 1/2.

6) 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.

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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 certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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

Under penalties of perjury, I declare that I have examined this 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. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: _____ Date: 4/15/05

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Commonwealth of Massachusetts

Board of Registration in Medicine

560 Harrison Avenue, G-4, Boston, Massachusetts 02118
Telephone (617) 654-9830

RECEIVED

JUL 28 2006

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:"**

(type or print clearly)

SEND LICENSE VERIFICATION TO: Medical Quality Assurance/Board of Medicine

ADDRESS: HMQAM 4052 Bald Cypress Way BIN#C03

CITY: Tallahassee, STATE: Florida ZIP: 32399-3253

(TYPE OR PRINT)
PHYSICIAN'S NAME: Jeffrey M. Good

BUSINESS ADDRESS: 110 Liberty st

CITY: Brockton STATE: Ma ZIP: 02301

MASSACHUSETTS LICENSE NUMBER: 46071

SIGNATURE OF PHYSICIAN: *Signed under the penalties of perjury*

DATE: 7/24/06

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

Dr. Jeffrey M Good

License Number: 46071

Data Date

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

In order for your license to be renewed you must take one of the following actions:

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

☑ My current NPI is: 1346223286

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to enclosed Taxonomy Code List). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: ☑ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☑ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 2/14/07

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dr. Jeffrey M Good

02/12/2007

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

PART A

1) Current Status: Active **Renewal Due Date:** 06/01/2007 **Birth Date**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page* 3.)

☑ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

2a) MAILING ADDRESS

RECEIVED
MAY 07 2007

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
Bridgewater Goddard Park
Med. Assoc.110 Liberty
Brockton, MA 02401-0000

Phone: (508)894-0328

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 508-894-0332

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information.
(See enclosed instructions and Renewal Instructions, page 4.)

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

FL. ___ ___ ___ ___ ___ ___

9) States where you were previously licensed

MD WI ND NY CA ___ ___

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Brockton Hospital			☐
Morton Hospital & Medical Center			☑
			☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 15 hrs/wk Change to: _____ hrs/wk

b) outpatient care 25 hrs/wk Change to: _____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 3/31/07 To 3/31/08

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one: ☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☑ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application.
(See Renewal Instructions, page 10.)

YES NO

23) Do you have a medical condition that interferes in any way or limits 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 (See Renewal Instructions, page 10.)

24) Have you used any chemical substance(s) which in any way interferes 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.

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

PART C

Check One: **PHYSICIAN PROFILE**

☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

CERTIFICATIONS

1) 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.

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

3) 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.

4) 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.

5) 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 1/2.

6) 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.

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

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 certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

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

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

Under penalties of perjury, I declare that I have examined this 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 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.

Signature: _____ Date: 5 / 2 / 07

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING. YOU MUST RETAIN A COPY OF YOUR APPLICATION FOR YOUR RECORDS, FOR CREDENTIALING AND FOR OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs, and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

In order for your license to be renewed you must take one of the following actions:

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

☑ My current NPI is: 1 3 4 6 2 2 3 2 8 6

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☑ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 5/2/07

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

PART A

1) Current Status: Active **Renewal Due Date:** 06/01/2009 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page* 3.)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

2a) MAILING ADDRESS

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

MAY 11 2009

Board of Registration in Medicine

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___)_____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Bridgewater Goddard Park
Med. Assoc.110 Liberty
Brockton, MA 02401-0000

Phone: (508)894-0328

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___)_____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 508-894-0332

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information.
(See enclosed instructions and Renewal Instructions, page 4.)

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

FL

9) States where you were previously licensed

MD WI ND NY CA

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Brockton Hospital			☐
Morton Hospital & Medical Center			☑
			☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 15 hrs/wk Change to: _____ hrs/wk

b) outpatient care 25 hrs/wk Change to: _____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 3/31/09 To 3/31/10

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. ***(See Renewal Instructions, page 5.)***

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☑ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application.
(See Renewal Instructions, page 10.)

YES **NO**

23) Do you have a medical condition that interferes in any way or limits 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 (See Renewal Instructions, page 10.)

24) Have you used any chemical substance(s) which in any way interferes 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.

Massachusetts Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.: 46071**

PART C

CERTIFICATIONS

1) 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.

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

3) 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.

4) 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.

5) 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 1/2.

6) 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.

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

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 certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

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

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

Check One: **PHYSICIAN PROFILE**

- ☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- ☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

Under penalties of perjury, I declare that I have examined this 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 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.

Signature: Jeffrey M Good MD Date: 5 / 8 / 09

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING. YOU MUST RETAIN A COPY OF YOUR APPLICATION FOR YOUR RECORDS, FOR CREDENTIALING AND FOR OTHER PURPOSES.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.:** 46071

Current Status: Active **License Expiration Date:** 6/29/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Signature Health
110 Liberty
Brockton
Massachusetts - 02401-0000
United States of America
(508) 894-0328

3) **Email Address:**

4) **Fax Number:** (508) 894-0332

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
Florida

9) **States where you were previously licensed**
California
Maryland
North Dakota
New York
Wisconsin

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

WorkSite	Location
Brockton Hospital	
signature health	brockton

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 15 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	10/01/2010	10/01/2011	Occurrence Policy

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

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

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

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

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

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

22) **Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.:** 46071

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[X] **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.**

[X] **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 Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.:** 46071

Current Status: Active **License Expiration Date:** 6/29/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Signature Health
2 washington st
no. easton
Massachusetts - 02356
United States of America
(508) 894-8740

3) **Email Address:**

4) **Fax Number:** (508) 894-0332

5) **Specialties**
Obstetrics and Gynecology

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

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

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California
Maryland
North Dakota
New York
Wisconsin

Physician Name: Jeffrey M Good, M.D. **License No.:** 46071

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

WorkSite	Location
Brockton Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 15 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	10/01/2012	10/01/2013	Occurrence Policy

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

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
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b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

22) **Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Jeffrey M Good, M.D. **License No.:** 46071

Compliance with Legal Responsibilities

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

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

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

[X] **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.**

[X] **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.**

Pacini, Robert

From: Jeffreyg47 < >
Sent: Wednesday, May 20, 2015 3:07 PM
To: Pacini, Robert
Subject: Profile

I do not plan to renew my license.
Lic # 46071
Current mailing address

Jeffrey Good

Sent from my iPad
Jeff

Douglas, Tara (MED)

From: Douglas, Tara (MED)
Sent: Tuesday, September 10, 2019 8:47 AM
To: 'ebmay@rediffmail.com'
Subject: RE: foia

Good morning Mr./Ms. May,

You can may input any ten digits if you do not want to disclose any of your own phone numbers. A phone number is requested in the event that the staff member processing the request has questions, and wishes to contact you via phone to clarify the request.

As noted on the Board website on public records, https://www.mass.gov/board-of-registration-in-medicine-public-records, "The Executive Office of Health and Human Services encourages you to use the form below to make a public records request (PRR) of the Board of Registration in Medicine. **This helps to ensure the most expeditious and accurate response to your request. Only questions pertaining to the PRR process or a PRR status should be sent to the email account of the Primary RAO**" (emphasis added).

This is to ensure a public records request is not lost or delayed. The Request Form is routed so that several Board staff members see a request made, and the process is streamlined, whereas sending a request directly to myself or anther staff *individually and directly* may get delayed due to staff vacations, unexpected absences, or other circumstances. For the above stated reasons, please make BORIM public records requests using the form at: https://www.mass.gov/forms/submit-a-board-of-registration-in-medicine-public-records-request.

Sincerely,
Tara

From: ebmay@rediffmail.com [mailto:ebmay@rediffmail.com]
Sent: Monday, September 09, 2019 8:19 PM
To: Douglas, Tara (MED)
Subject: Re: foia

The website form is illegal. No phone number is needed for a foia request. I'm appealing.

From: "Douglas, Tara R (MED)" <tara.r.douglas@state.ma.us>
Sent: Tue, 10 Sep 2019 01:07:39
To: "ebmay@rediffmail.com" <ebmay@rediffmail.com>
Subject: Re: foia

Good afternoon,

Please submit any and all public records requests through the online form at: https://www.mass.gov/forms/submit-a-board-of-registration-in-medicine-public-records-request. Once submitted and received through the BORIM public records request form, the request receipt date will be documented, and the request processed accordingly.

Thank you,
Tara

From: ebmay@rediffmail.com [mailto:ebmay@rediffmail.com]
Sent: Monday, September 09, 2019 3:34 PM

To: Douglas, Tara (MED)
Subject: foia

Per the foia please send all the documents in the file pertaining to:

Jeffrey M. Good, M.D.
46071

License Number

thank you very much.
EB May

The Commonwealth of Massachusetts
William Francis Galvin, Secretary of the Commonwealth
Public Records Division

Rebecca S. Murray
Supervisor of Records

September 10, 2019
SPR19/1861

EB May

Dear EB May:

I have received your letter appealing the response of the Board of Registration in Medicine to your request for records.

I have directed a member of my staff, Fredson Sossavi, to review this matter. Upon completion of the review, I will advise you in writing of the disposition of this case. If in the interim you receive a satisfactory response to your request, please notify this office immediately.

Any further correspondence concerning this specific appeal should refer to the SPR case number listed under the date of this letter.

Sincerely,

Rebecca Murray

Rebecca S. Murray
Supervisor of Records

cc: Tara Douglas, Esq.

Nathan, Kevin

From: ebmay@rediffmail.com on behalf of eb may <ebmay@rediffmail.com>
Sent: Monday, September 9, 2019 8:21 PM
To: SEC-DL-PREWEB
Subject: Fw: foia

Dear Appeal dept,

This medical board employee insists that I submit my foia via the webform. I do not have a phone nor phone number and so cannot submit it by the webform. The webform seems illegal. Please obtain the requested documents. Thank you very much.

From: "Douglas, Tara R (MED)" <tara.r.douglas@state.ma.us>
Sent: Tue, 10 Sep 2019 01:07:39
To: "ebmay@rediffmail.com" <ebmay@rediffmail.com>
Subject: Re: foia

Good afternoon,

Please submit any and all public records requests through the online form at: https://www.mass.gov/forms/submit-a-board-of-registration-in-medicine-public-records-request. Once submitted and received through the BORIM public records request form, the request receipt date will be documented, and the request processed accordingly.

Thank you,
Tara

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Sent: Monday, September 09, 2019 3:34 PM
To: Douglas, Tara (MED)
Subject: foia

Per the foia please send all the documents in the file pertaining to:

Jeffrey M. Good, M.D.
46071

License Number

thank you very much.
EB May

Douglas, Tara (MED)

From: ebmay@rediffmail.com on behalf of eb may <ebmay@rediffmail.com>
Sent: Monday, September 23, 2019 8:11 PM
To: Douglas, Tara (MED)
Subject: Re: You have files

Dear Ms. Douglas,

I've downloaded the file yet it is not a pdf and I can't open. Please email it in parts if you have to. Thank you.

From: "Douglas, Tara R (MED)" <tara.r.douglas@state.ma.us>
Sent: Mon, 23 Sep 2019 23:55:35
To: ebmay@rediffmail.com, pre@sec.state.ma.us
Subject: You have files

You have received file(s) containing protected information sent through the Commonwealth of Massachusetts' Interchange System from tara.r.douglas@state.ma.us.

Click or paste the following URL into your browser to retrieve your file(s).
https://ics.mass.gov/DynIC/getreslist.do?tid=297122

Files transferred to you through this system may contain confidential and/or personally identifiable information

Douglas, Tara (MED)

From: ebmay@rediffmail.com on behalf of eb may <ebmay@rediffmail.com>
Sent: Thursday, September 26, 2019 8:05 PM
To: Douglas, Tara (MED)
Subject: Re: You have files

I can not open the folder for the pdfs. I do not have an program to open it. Please email it in parts. Thank you.

From: "Douglas, Tara R (MED)" <tara.r.douglas@state.ma.us>
Sent: Wed, 25 Sep 2019 21:24:29
To: ebmay@rediffmail.com, pre@sec.state.ma.us
Subject: You have files

You have received file(s) containing protected information sent through the Commonwealth of Massachusetts' Interchange System from tara.r.douglas@state.ma.us.

Click or paste the following URL into your browser to retrieve your file(s).
https://ics.mass.gov/DynIC/getreslist.do?tid=297289

Files transferred to you through this system may contain confidential and/or personally identifiable information