Application #: 212521
Date of Issue: _____

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

FULL LICENSE APPLICATION

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

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

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

Maglaire Christ-Ann Andrée
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☑

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: Month Day Year Social Security Number: _____

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

Home Address: _____
Number and Street

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

Business Address: 91 East Concord St. Mat Bldg-3 BUMC
Number and Street

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

Business Telephone: (617) 414-5593 ext. _____ Home Telephone:

Preferred Mailing Address: ☐ Business Address ☒ Home Address

PRINT NAME: Christ-Ann Magloire PAGE 2 OF 3

Pre-medical School

Facility: Temple University Degree: B.S. From 08/88 To 08/92
Street: N. Broad Street City: Philadelphia State: PA

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

Medical School

Facility: Howard University Degree: M.D. From 08/95 To 05/99
Street: 520 W Street N.W. City: Washington State: D.C.

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

Date of medical school graduation: 5/99

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

Postgraduate Education:

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

Facility: Nassau University Medical Center Position: PGY 1+2 Resident Physician From 7/1/99 To 6/30/01
Street: 2001 Hempstead Tpke. City: East Meadow State: N.Y.

Facility: Boston University Medical Center Position: Resident-3 physician 7/1/01 __/__/__
Street: 1 One Boston Medical Center Place City: Boston State: MA

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

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

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

PRINT NAME: Christ-Ann Magloire, M.D.

Hospital Affiliations and Employment

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

		From	To
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______		State: ____

1. List other states (abbreviations) where you are currently or have ever been licensed: NY
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): ______
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: employment for the future
6. Name of Facility: ______
7. Address: ______ City: ______
8. Anticipated starting date in Massachusetts: ____/____/____

Affidavit of Applicant

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

[signature]

Signature of Applicant

Date 9/10/01

2/16/2001

Christ-Ann Magloire, M.D.

OBJECTIVE To obtain a residency position in Obstetrics and Gynecology

EDUCATION

Nassau University Medical Center – SUNY Stony Brook
East Meadow, New York Resident Physician – Ob/Gyn
July 1999 -

Howard University College of Medicine – Washington, D.C.
Doctor of Medicine – May, 1999

Temple University - Philadelphia, Pennsylvania
B.S. Community Health Education, Minor in Social Work – 1992

WORK EXPERIENCE

National Institutes of Health – Institute of Child Health and Human Development
NIH/ D.C. Initiative to Reduce Infant Mortality in Minority Populations of D.C.
Protocol – Barriers of Entry into Prenatal Care June 1997 – August 1997

Intramural Research Training Fellow

- Recruit and interview women during their first prenatal care visit
- Review and withdraw information from medical records of pregnant and postpartum women
- Serve as a liaison with staff in Medical Records from various hospitals, clinics and private offices in Washington, D.C.
- Participate in ongoing meetings with other study personnel to review data
- Conduct exit interviews with postpartum women summarizing the outcomes of their prenatal experience
- Present poster representing research experience at NIH Research Symposium

Madonna Heights Services
Dix Hills, New York January 1995 – August 1995

Child Care Worker

- Counsel emotionally disturbed girls from ages 12 to 17
- Monitor and evaluate residents' emotional disabilities
- Implement programs to encourage youth development

Cornell Cooperative Extension
Plainview, New York November 1994 – August 1995

Project Coordinator – Parent HIV/AIDS Education Project

- Develop a team strategic plan for implementing project in Nassau County, NY
- Conduct a series of intensive 2 – 3 day in-service workshops for groups of Volunteer Educators as a co-facilitator

- Provide ongoing support to trained Volunteer Educators through individual consultation and coordinated meetings

Resurrection House, Incorporated
Wheatley Heights, New York October 1994 – August 1995

Shelter Worker
- Supervise the general activities of all residents
- Provide conflict resolution between residents as needed
- Organize, encourage and participate in "family time" including age appropriate programs

Project Chance – Project Teen-Aid, Incorporated
Brooklyn, New York September 1992 – July 1993

Health Services/ Outreach Coordinator
- Provide leadership for program design and implementation, evaluating all aspects for cost saving benefits and program progress
- Develop and implement linkages with community health care providers for free and low-cost services
- Develop and implement tracking systems for monitoring prenatal care, well baby care and immunizations for research component
- Organize a referral list and data base of specialists to provide on-site preventive screening to the children and adults

Temple University Hospital – Temple Infant Parent Support Services
Philadelphia, Pennsylvania May 1992 – August 1992

Health Educator
- Plan and conduct prenatal, family planning and positive parenting educational programs for the clients
- Evaluate and revise program content and methods continually for research component
- Coordinate and liaison with hospital personnel and community organizations as a client advocate

SERVICE ACTIVITIES
Eta Sigma Gamma – Professional Health Honorary Society
Member of Delta Sigma Theta Sorority, Inc.
Member of American Medical Women's Association
Member of National Medical Association
Member of American College of Obstetrics and Gynecology – Jr. Fellow

REFERENCES Available upon request

07002820251

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NOV 30 2001
Board of Registration in Medicine

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DEC 18 2001
Board of Registration in Medicine

POSTGRADUATE VERIFICATION

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 9/18/01

Print or Type Name: Christ-Ann Magloire, M.D.

Name of Institution: Nassau University Medical Center → Boston University

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Nassau University Medical Center.

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

Enrollment and Participation: Our records indicate that Christ-Ann Magloire MD. participated in the following program:
(type or print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1,2	OBGYN	7 1 1999	6 13 01	yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Rd Magloire

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Christ Ann Magloire MD.

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

QUESTIONS	**YES**	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

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

COMMENTS

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Elsie M. Santana Fox MD

Print Name: Elsie M. Santana-Fox MD.

Academic Title: Program Director

Telephone: (516) 572-6254 Today's Date: 10/25/01

0702020281 8

POSTGRADUATE VERIFICATION

RECEIVED OCT 12 2001 BOARD OF REGISTRATION IN MEDICINE

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 9/13/01

Print or Type Name: Christ-Ann Magloire, M.D.

Name of Institution: Boston University Medical Center.

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Boston University Medical Center

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

Enrollment and Participation: Our records indicate that Christ-Ann Magloire participated in the following program:
(type or print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	3	OB/Gyn	7/1/01	6/30/02	NO	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

(AW) 10/4/01

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Christ-Ann Magloire, M.D.

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

QUESTIONS	**YES**	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

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

COMMENTS:_____

_____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Phillip G. Stubblefield, M.D.

Print Name: Phillip G. Stubblefield, M.D.

Academic Title: Chief, Program Director

Telephone: (612)414-5125 Today's Date: 9/17/01

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

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

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

October 19, 2001

Christ-Ann A Magloire, M.D.

Re: Application Number 212521

Date Application Received: 10/18/2001

Dear Dr. Magloire :

Your application for a full medical license in Massachusetts was received on the above date.

The Licensing Unit will assist you in expediting the processing of your application, however, please be advised that it can take up to twelve (12) weeks to process an application. Throughout this process, we will provide you with periodic updates regarding the status of your license application.

You will receive a notification of missing documents for your full license application in four weeks. Please be advised that if your full license application is incomplete after 6 months, you will be required to update the application and specific documents that are 6 months old. For additional licensing information, you may access the Board's website at www.massmedboard.org .

Sincerely,

Licensing Staff

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

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return with your application. Massachusetts General Laws Chapter 62C, §49, requires that you complete this statement to obtain licensure to practice a profession:

I, Christ-Ann Magloire, M.D.,
(type or print name)

certify, under the penalties of perjury, to my best knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: _____ DATE: 9/10/01

Social Security Number: _____

****

Massachusetts General Laws Chapter 112, §5, and 243 CMR 2.04 (2) (k) require that you complete the following statement:

I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

SIGNED: _____ DATE: 9/10/01

Revised 04/20/97

SUPPLEMENT FORM

PRINT NAME: Christ-Ann Magloire, M.D DATE: 09/10/01

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

		YES	NO
1.	Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2.	Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
3.	Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5.	Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?		
6-A.	Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7.	Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards?		
8-A.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

PRINT NAME: Christ-Ann Magloire, M.D.

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: _____ **Date:** 9/10/01

CONFIDENTIAL MEDICAL INFORMATION

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

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

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

Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)

Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting Child Support.

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

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

Applicant's Signature: _____ **Date:** 09/10/01

PRINT NAME: Christ-Ann Magloire, M.D.

Signature: _____ Date: 9/10/01

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. This statement should be executed by someone other than a relative who has known you for a substantial period of time. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH

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

Kathleen McCluskey
Signature of Notary

4/16/2004
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Christ-Ann Magloire, M.D.
(name of applicant)

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

Signature of applicant

Yvette Nicole Owens, M.D.
Signature of Certifying Physician

222806 NY
License Number State

YVETTE NICOLE OWENS, M.D.
Type or print name clearly

Address: 1400 Pelham Pkwy S and Eastchester Rd
City: Bronx
State: NY Zip: 10461
Telephone: (718) - 918-5824
Date: 10/10/01

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

10/19/01

07020200251

RECEIVED
SEP 26 2001
BOARD OF REGISTRATION IN MEDICINE

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

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

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

Applicant's Signature: _____ Date of Birth 11/05/70

Print or Type Name: Maglbire, (Last name) ChristAnn (First Name) A. (Middle Initial) Social Security No: 083681908

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

Name of Medical School: Howard University College of Medicine

Address: 520 W Street N.W. City: Washington DC State or Province: _____

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Temple University

Undergraduate School Address: Philadelphia, PA

Continued on back

10/19/01

07020AM0261 61

Enrollment and Participation: Our records indicate that Maglorie Christ-Ann A

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	8 / 21 / 95	5 / 10 / 96	8 / 31 / 98	5 / 8 / 99
	8 / 26 / 96	5 / 16 / 97	/ /	/ /
	8 / 19 / 97	8 / 26 / 98	/ /	/ /
	/ /	/ /	/ /	/ /

The applicant attended _____ total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one [X] was awarded a degree in Doctor of Medicine on (month/day/year) 5 / 8 / 99

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

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

	YES	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Pauline Y. Titus-Dillon

Print Name: Pauline Y. Titus-Dillon, M.D.

Title: Associate Dean for Academic Affairs

Date: 9 / 20 / 01 Telephone: (202) 806-6280

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, MAGLOIRE CHRIST-ANN ANDREE ELIZABETH WAS ISSUED LICENSE/CERTIFICATE NUMBER 220187 FOR THE PRACTICE OF MEDICINE ON 01/23/01.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH:
SCHOOL ATTENDED: HOWARD UNIVERSITY
DATE OF GRADUATION: 05/09/99
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	EXAMINATION	SCORE
12/00	USMLE STEP 3	
08/98	USMLE STEP 2	
10/97	USMLE STEP 1	

EXMS TAKEN=03

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 12/31/02
ADDRESS:

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Geboski 09/13/01
PRINCIPAL CLERK

OP026 056

07/02/2002231 66

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RECEIVED NOV 30 2001 Board of Registration in Medicine

RECEIVED DEC 18 2001 Board of Registration in Medicine

POSTGRADUATE VERIFICATION

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 9/18/01

Print or Type Name: Christ-Ann Magloire, M.D.

Name of Institution: Nassau University Medical Center → Boston University

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Nassau University Medical Center.

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

Enrollment and Participation: Our records indicate that Christ-Ann Magloire MD. (type or print applicant's name) participated in the following program:

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1,2	OBGYN	7 1 99	6 30 01	YES	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

10/10/01

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Christ Ann Magloire MD.

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

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

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

COMMENTS

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Elsie M. Santana Fox MD

Print Name: Elsie M. Santana-Fox MD.

Academic Title: Program Director

Telephone: (516) 572-6254 Today's Date: 10/25/01

0702020028 1   68

POSTGRADUATE VERIFICATION

BOARD OF REGISTRATION IN MEDICINE · MASSACHUSETTS

RECEIVED OCT 12 2001 BOARD OF REGISTRATION IN MEDICINE

Commonwealth of Massachusetts--Board of Registration in Medicine

10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 9/13/01

Print or Type Name: Christ-Ann Magloire, M.D.

Name of Institution: Boston University Medical Center.

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Boston University Medical Center

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

Enrollment and Participation: Our records indicate that Christ-Ann Magloire participated in the following program:
(type or print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	3	OB/Gyn	7/1/01	6/30/02	No	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

(AM) 10/24/01

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Christ-Ann Magloire, M.D.

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

QUESTIONS	**YES**	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

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

COMMENTS: _____

_____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Phillip G. Stubblefield MD

Print Name: Phillip G. Stubblefield, M.D.

Academic Title: Chief, Program Director

Telephone: (617) 414-5125 Today's Date: 9/17/01

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
Fax: (617) 426-9358 Website address: www.massmedboard.org

MALPRACTICE HISTORY

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

Waiver for Release of Information

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

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

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. The liability carrier must return this form directly to the Board at the above address.

Liability Carrier: (RRG) Promutual Insurance **From:** ___/___ **To:** ___/___
City: _____ State: _____ Policy Number: _____

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

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

Applicant's signature: _____ 2/22/02
Date

Print Name: Christ Ann Madorine

Address: _____ City: _____

State: _____ Zip code: _____

You may download additional forms at the Board's website at www.massmedboard.or

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

MALPRACTICE HISTORY

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

Waiver for Release of Information

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

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

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

Dates of Issue

Liability Carrier: Nassau County Medical Center **From:** 7/01/99 **To:** 6/30/01
City: East Meadow State: N.Y.
Policy Number: -----

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

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

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

Signed: _____ 11/15/01 Date

Print Name: Christ-Ann Malvoire, MD

July 1999 - June 2001 Obgyn (617) 426-9358

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Christ-Ann Magloire, M.D.
(type/print your complete name)

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

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

Board of Registration in Medicine
10 West Street, Boston, MA 02111
Attention: Licensing

Immunity and Release

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

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons must be sent directly by the persons to the Board of Registration in Medicine. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me.

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

Applicant's Signature — Date of Signature: 9/10/01

Magloire, Christ-Ann, A.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
Fax: (617) 426-9358 Website address: www.massmedboard.org

MALPRACTICE HISTORY

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

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

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

NONE

Liability Carrier's Instructions: **If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. The liability carrier must return this form directly to the Board at the above address.**

Liability Carrier: NASSAU UNIVERSITY MEDICAL CENTER
City: East Meadow State: NY From: 7/99 To: 6/01 Policy Number: NUMC - Self-Insured

Liability Carrier: _____
City: _____ State: _____ From: __/__ To: __/__ Policy Number: _____

Liability Carrier: _____
City: _____ State: _____ From: __/__ To: __/__ Policy Number: _____

Applicant's signature: _____ 2/22/02
Date

Print Name: Christ-Anne Magliore

Address: _____

State: _____ City: _____

Zip c _____

You may download additional forms at the Board's website at www.massmedboard.org

FEB 22 2002

N.C.M.C. RISK MGT.

rnl 7-9-01 #3483

RECEIVED JUL 7, 2001 BOARD OF REGISTRATION IN MEDICINE

Application #: 212460
Date Approved: 7/11/01

Commonwealth of Massachusetts- Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111 - www.massmedboard.org

INITIAL LIMITED LICENSE APPLICATION

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

CHECK ONE:

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

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) Magloire (First) Christ-Ann (MI) A

1-B. Other Name(s): _____

1-C. Mother's Maiden Name: _____

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

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

2. Current Residence: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

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

4. Sex: [ ] Male [X] Female 5. Social Security Number:

6. Name of Massachusetts Training Hospital: Boston University Medical Center

One Boston Medical Center Place Boston, MA
(Street Address) (City)

PRINT NAME Christ-Ann Magloire, M.D.

7. Name of premedical school(s): Temple University

   Location: Philadelphia, PA USA
   (City, State, Country)

8. Name of medical school(s): Howard University

   Location: Washington, D.C.
   (City, State, Country)

   Date of Graduation: 05 / 09 / 99 Degree: ☒ M. D. ☐ D. O. Other(specify)_____
   (Month) (Day) (Year)

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

   Name of Institution: Nassau University Medical Center

   Address: 2101 E. Hempstead Tpke East Meadow, N.Y.

   Name of Program: Ob/Gyn Dates of Training: 7/99-6/01

   (If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *currently* have a license to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or training license (L).

NY ☒(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

11. List states (abbreviations) where you were <u>previously</u> licensed to practice medicine (include residency-training licenses). Indicate whether full license (F) or residency or limited license (L).

____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

<u>YES</u> <u>NO</u>

12-A. If you are a USMG, have you taken more than <u>4 years</u> to complete medical school?

12-B. If you are an IMG, have you taken more than <u>6 years</u> to complete medical school? If **yes**, you must provide additional information. (See instructions).

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? If **yes**, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

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

This certifies that Christ-Ann MacLoire, M.D. has been appointed
(Name of Applicant)

to the position of ☐ Intern ☑ Resident ☐ Fellow

in the specialty of Obstetrics & Gynecology as a PGY 3

Department: OB/Gyn Subspeciality: _____

at Boston Medical Center
(Name of Healthcare Facility)

beginning 7 / 1 / 01 to anticipated completion of training: 6 / 30 / 03.
(Month) (Day) (Year) (Month) (Day) (Year)

	YES	NO
1. Is the program accredited by the ACGME?	☑	☐
2. If **no**, is there an ACGME-approved training program in the applicant's specialty ?	☐	☐
3. Have you reviewed Sections A and C of the limited license application?	☑	☐

Designated Official's Signature: Maxine Kessler

Type or Print Name: Maxine Kessler

Official Title: Director, Graduate Medical Education

Date: 7 / 3 / 01 Telephone Number: 617-414-5423

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

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

	YES	NO
14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).		
If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.		
15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16-A. Have you ever been terminated by a medical school or postgraduate training program?		
16-B. Have you ever been granted a leave of absence by a medical school or a postgraduate training program?		
16-C. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?		
If you answered "yes" to 16-A, B or C, a letter from your medical school(s) or postgraduate training program(s) is required.		
17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		

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

PRINT NAME: Christ-Ann Magloire, M.D.

CONFIDENTIAL MEDICAL INFORMATION

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

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

If your responses to Questions 15-35 change *while your application is pending*, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

CERTIFICATIONS:

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- 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 will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: _____ **Date:** 6/29/01

LIMITED LICENSE APPLICANT

Commonwealth of Massachusetts Board of Registration in Medicine

10 West Street, 3rd Floor, Boston, Massachusetts 02111 (617) 727-3086
www.massmedboard.org.

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

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

Signature of physician: _____ Date: 6 / 15 / 01

Print or type name: Christian Maguire, MD.

License number: 220187-1 Status of license: ☒ Active ☐ Inactive ☐ Other _____

TO BE COMPLETED BY STATE BOARD

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

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

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

Signed: _____

BOARD SEAL

Print Name: _____

Title: _____

State Board: _____ Date: ___/___/___

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Christ-Ann Magloire, M.D.
(type/print your complete name)

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

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

Immunity and Release

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

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

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

Applicant's Signature — Date of Signature: 6/14/01

Magloire, Christ-Ann A.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

COMPLETED

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

RECEIVED
NOV - 4 2002
BOARD OF REGISTRATION IN MEDICINE

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

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

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

1. Current Status: Active Registration No.: 212521 Renewal Date: 11/05/2002

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

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

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

A) Mailing/Business Address:

3. Christ-Ann A Magloire

B) Home Address:

Home Phone:

Business Phone: (617)265-8377

Please make corrections (type or print)

Other Name(s): _____

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

Business Address: 91 East Concord Mat. 3
City/Town: Boston State: MA
Zip: 02118 Country: USA
Business Telephone: (617) 414-5593

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

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

5.a) Name of Medical School:
Howard University College of Medicine
b) Year Graduated: 1999 M.D. c) Degree:

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

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

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

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

9. a) Other states where you are now licensed to practice (Abbr.)

b) States where you were previously licensed (Abbr.)
N Y

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

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

PRINT YOUR LAST NAME: Magloire LICENSE NUMBER: 212521

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

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

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

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

1) Average weekly hours involved in: a) outpatient care 0 hrs/wk b) inpatient care 0 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 100 %

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: 11/4/02

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

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

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING

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: 11/4/02

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

212521

Christ-Ann Magloire. MD

March 23, 2005

Board of Registration of Medicine
560 Harrison Avenue Ste. G4
Boston, MA 02118
Attn: License Department

To whom it may concern:

I would like to notify you of my address change. My license number is 212521. As well, I would like to reactivate my license. If you could please send the appropriate paperwork to the above address or fax number 305 899-0551.

Thank you in advance,

C. Magloire

RECEIVED
2005 APR -1 PM 2:22
BOARD OF REGISTRATION IN MEDICINE

600.00$ #834 12/16/08

MA License Number: 21252
Date license revived: ___/___/___

05/19/09 $2

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

DEC 2 2008 Board of Registration in Medicine

LAPSED LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

Activity Status: ☒ Active ☐ Inactive*

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

Magloire | Christ-Ann | Andrée | _____
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

Medical Degree: ☒ M.D. ☐ D.O. ☐ Ph.D. ☐ Other degree_____

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

_____ | _____ | _____ | _____
Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

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

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

Home Address: _____ (Number and Street)

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

Business Address: 1190 N.W. 95th street Suite 110 (Number and Street)

Miami (City) Florida (State/Province/Territory) 33150 (Zip (or postal) Code)

Business Telephone: (305) 696-7759, ext. _____ Home Telephone: _____

E-mail Address_____ Fax Number: (305) 829-1546

Preferred Mailing Address: ☐ Business Address ☒ Home Address

Cell

*Inactive status: If you check inactive status when you sign the lapsed application, you certify that you will not practice medicine in Massachusetts.

APPLICANT'S NAME: Christ-Ann Magloire

Postgraduate Education:

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

		From	To
Facility: Nassau University Medical Center	Position: PGY 1-2	7/1/99	6/30/01
Street: 2201 Hempstead Turnpike	City: Eastmeadow	State: NY. 11554	
Facility: Boston University Medical Center	Position: PGY 3-4	7/1/01	6/30/03
Street: One Boston Medical Center Place	City: Boston,	State: MA 02118	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

Hospital Affiliations and Employment

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

		From:	To:
Facility: North Shore Medical Center	Position: Active Attending	11/1/03	present
Street: 1100 N.W. 95th street	City: Miami	State: Fl 33150	
Facility: Parkway Regional Medical Center	Position: Active Attending	11/1/03	1/1/06
Street: 909 N.E. 163 street	City: North Miami Beach	State: Fl	
Facility: Palmetto General Hospital	Position: Attending	4/01/08	- present
Street: 2001 W. 68th street	City: Hialeah	State: FL	
Facility: Unemployed (vacation)	Position:	6/30/03	9/27/03
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

APPLICANT'S NAME: Christ-Ann Magloire

Medical Malpractice Information:

My medical malpractice insurance coverage is by: ☒ Insurance carrier ☐ Letter of Credit

Print name of insurer: Federal Tort Claims Act (FTCA) Triton Group

Policy dates: From: 1/1/09 To: 12/31/09

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

☐ I am not involved in direct patient care ☐ Otherwise exempt

Explain exemption _____

Continuing Medical Education Credits

Read instructions for continuing medical education requirements before completing.

Activity status: ☒ Active ☐ Inactive ☐ Exemption _____

Category 1 credits 144
Category 2 credits 80

Risk management Category 1 8
Risk Management Category 2 6

Continuing medical education credit requirements must be completed before the Lapsed License can be revived if you are applying for active license status. (See Lapsed License Instructions).

1. List other states (abbreviations) where you are currently or have ever been licensed: NY FL
2. Are you certified by the American Board of Medical Specialties (ABMS)? ☒ Yes ☐ No
3. List only ABMS certification(s): passed Oral Boards 1/09
4. Reason for reviving Lapsed License in Massachusetts: Anticipate moving to Boston in 6/09 for position as hospitalist
5. Please attach your current curriculum vitae

Continued on page 4

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 the penalties of perjury, I declare that I have examined this lapsed 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 revival of a lapsed 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: 3/6/09

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

Continued on Page 5

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 the purposes of conducting these business transactions. Under the HIPPA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order to complete your license application 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 (see instructions for Option 2).

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

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

☑ My current NPI is: 1 0 9 3 7 8 0 2 0 7

☐ I have personally applied for an NPI.

☐ 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.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (See Lapsed License Instructions, pages 7. 8 and 9). 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:	2 0 7 V 0 0 0 0 0 X	Obstetrics & Gynecology
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 to any authorized hospital, health plan or health organization.**

Signature: _____ Date: 3/16/09

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Christ-Ann Maguire
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature — Date of Signature: 3/16/09

Maguire, Christ-Ann A.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, Christ Ann Magloire, MD
(type or print name)

certify, under the penalties of perjury, to my best knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: _____ DATE: 3/16/09

Social Security Number: _____

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.04 (2) (k) require that you complete the following statement:

I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: 3/16/09

Revised 9/23/2008

CHRIST-ANN MAGLOIRE, MD

Home and Fax
| Cellular

camagloire@hcnetwork.org

OBJECTIVE

To obtain a Master in Public Health to complement providing healthcare to women as an Ob/Gyn

EDUCATION

Sept. 1, 1988 - May 15, 1992	Bachelor of Science Temple University	Community Health Education Philadelphia, PA
Sept. 1, 1995- May 8, 1999 -	Doctor of Medicine Howard University	College of Medicine Washington, DC

POSTDOCTORAL TRAINING

July 1, 1999 Jun 30, 2001	Internship/Residency Department of Obstetrics & Gynecology	Nassau University Medical Center East Meadow, NY
July 1 -2001 Jun 30, 2003	Residency Department of Obstetrics & Gynecology	Boston University Medical Center Boston, MA

SCIENTIFIC ACTIVITIES

2004	The Risk of Adverse Pregnancy Outcomes in the Haitian Population at Boston Medical Center National Medical Association Residents' Research Finalist Annual Meeting San Diego, CA
2004	Research Poster – Haitian Pregnancy Outcomes American College of Obstetrician/Gynecologists Annual Meeting Philadelphia, PA
2002	Participant IPAS/ARHP Partners Program Planning Meeting on Manual Vacuum Aspiration Abortion Training Chapel Hill, North Carolina
2002	Presentation Reproductive Health Initiative American Medical Women's Association Annual Meeting " Insights from Haiti: An International Reproductive Health Experience " San Diego, CA
2002	Case Presenter "Stump the Professors" American College of Obstetrician/Gynecologists

2001 Update on the Management of Leiomyomas
ACOG Annual Meeting

2001 Co-investigator, Novel Custom Fit Cervical Cap (KOCAP)
Phase II Clinical Trials James P. Koch, P.I.
Brigham & Women's Hospital Boston, MA

2001 Co-investigator, Randomized study of the effect of laminaria induction-to-abortion time for second trimester induction abortion
Lynn Borgatta, P.I. Boston Medical Center Boston, MA

2001 Revision of Current Cerclage Placement Guidelines
Boston Medical Center Dr. Anjun Chaudury

2001 Research Associate –Gyn Infections Follow-Through (GIFT) Study – Boston University Dr. Lynn Borgatta, Dr. Tim Rice

1989-1991 Laboratory Assistant Animal Lab Department of Psychology
Temple University Philadelphia, PA

1997 NIH Research Poster Presentation
" Barriers of Prenatal Care in an African-American teenage urban population " - D.C. Infant Mortality Reduction Project

PUBLICATIONS

Female Genital Cancers Association of Family Practice Medicine
Clinical Monologue Co-Writer Dr. Josephine Fowler

A randomized clinical trial of the addition of laminaria to misoprostol and hypertonic saline for second-trimester induction abortion. **Contraception,** Volume 72, Issue 5, pages 358-361 L. Borgatta, A. Chen, O. Vragovic, P. Stubblefield, C. Magloire

PROFESSIONAL EXPERIENCE

2003 - present **Economic Opportunity Family Health Center** Miami, Florida

General Obstetrician/Gynecologist

- Provide prenatal, antepartum, intrapartum and postpartum care
- Conduct annual exams including colposcopy, surveillance and treatment for abnormal pap smear results
- Counsel patients on contraception and family planning methods for reproductive and infertile challenged patients

1997 **National Institutes of Health – Institute of Child Health and Human Development** Bethesda, Maryland

Intramural Research Training Fellow

- Recruit and interview women during their first prenatal care visit
- Review and collect information from medical records of pregnant and postpartum women
- Conduct exit interviews with postpartum women summarizing the outcomes of their prenatal experience

1994 – 1995 **Cornell Cooperative Extension** Plainview, New York

Project Coordinator – Parent HIV/AIDS Education Project

- Develop a team strategic plan for implementing project in Nassau County, New York
- Conduct a series of intensive 2 – 3 day in-service workshops for groups of Volunteer Educators as a co-facilitator
- Provide ongoing support to trained Volunteer Educators through individual consultation and coordinated meetings

1992 – 1993 **Project Teen-Aid, Incorporated** Brooklyn, New York

Health Services/ Outreach Coordinator

- Provide leadership for program design and implementation, evaluating all aspects for cost saving benefits and program progress
- Develop and implement linkages with community health care providers for free and low-cost services
- Develop and implement tracking systems for monitoring prenatal care, well baby care and immunizations for research component

1992 **Temple University Hospital – Temple Infant Parent Support Services** Philadelphia, Pennsylvania

Health Educator

- Plan and conduct prenatal, family planning and positive parenting educational programs for the clients
- Evaluate and revise program content and methods continually for research component
- Coordinate and liaison with hospital personnel and community organizations as a client advocate

MEDICAL LICENSURE

New York State Full License 2001 - present
Florida Full License 2003 – present
USMLE Parts I, II, III

LANGUAGES

Medical Spanish & Haitian Creole

SERVICE ACTIVITIES

2003– present Member – Haitian Physicians Association – South Florida
2001–2003 Member of Minority Recruitment Committee – Boston Medical Center
1999–present American College of Obstetrics & Gynecology – Jr. Fellow
1999-2000 ACOG – Jr. Fellow Vice Chair – Section IV – District II
2000-2001 ACOG – Jr. Fellow Chair – Section IV – District II
1999-present Member – National Medical Association
1995 – present Member – American Medical Women's Association

AWARDS RECEIVED

2003 NMA Ob/Gyn Resident Research Symposium Finalist – San Diego
2001 & 2002 Wyeth Ayers Young Reproductive Leaders Award
1999 Howard University Student Ambassador Admissions Service Award
1999 School of Medicine Student Council Service Award
1999 Howard University Obstetrics & Gynecology Society – President and founder (1998-1999) Service Award
1999 Service Award Graduate Student Assembly – Vice-President '97 –'99
1998 Edith Seville Zonta Memorial Scholarship
1998 Carol Mc Kinney Alumni Scholarship
1996 National Health Services Scholarship

REFERENCES

Available upon request

SUPPLEMENT FORM FOR LAPSED APPLICATION

PRINT NAME: Christ-Ann Maglaire, M.D. DATE: 11/15/08

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

QUESTIONS	YES	NO
1-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
1-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
2. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
3-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
3-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		
4-A. Have you ever voluntarily relinquished any medical staff membership?		
4-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
4-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
4-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
5. Have you ever been charged with any criminal offense, other than a minor traffic offense?		
6. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		

Signed: _____ Date: 11/15/08

		YES	NO
7.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
8.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
9.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
10-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
10-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: _____ Date: 11/15/08

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplement pages for questions #11-A to 14. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

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

If your responses to Questions 1-14 change while your lapsed application is pending, you must immediately notify the Board of the new information.

Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)

Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting Child Support.

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

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.

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

Applicant's Signature:_____ Date: 11/15/08

QUESTIONS #1-A & 1-B – License application withdrawal, denial or license surrender

Attach additional pages with same format where necessary.

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

State: _____ Year: ____/____/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding the withdrawal, denial or voluntary surrender directly to the Board. Such documentation must specify the reason(s) for denial, withdrawal of your license application or voluntary surrender of your license.

QUESTION #2 – Lost or denied American Board of Medical Specialties certification

Specialty Board: _____ Date of action: ____/____/____

Explain reason(s) for loss or denial: _____

QUESTIONS #3-A & 3-B – Disciplinary actions

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

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

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.

Signature: _____ Date: 11/15/09

PRINT NAME: Christ-Ann Maglaire, MD

QUESTIONS #4-A, 4-B, 4-C, and 4-D – Medical staff membership, status and/or privileges

Attach additional pages with same format where necessary. Describe circumstances leading to change in medical staff membership, status and privileges:

Name of facility:_____ Date of action :____/____/____
Address:_____ City: _____ State: ___Zip:_____
Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 4-A through 4-D directly the Board.

QUESTION #5 – Criminal proceedings

Attach additional pages with same format if more than one charge and where otherwise necessary.

Court:_____ Charge: _____ Date: ____/____/____

Please attach a detailed account of circumstances leading up to criminal proceedings.

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant directly to the Board.

Signature: _____ Date: 11/15/08

Print Name: Christ-Ann Maguire, M.D.

QUESTION #6 – Controlled substances privileges
Attach additional pages with same format where necessary.

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

Circumstances of Restriction:

_____

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact and correspondence related to any affirmative response directly to the Board.

QUESTIONS #7, 8 and 9 – Liability insurance and provider restrictions, denial, and revocation

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

Action: _____

Explain reason(s) for action:

_____

Signature: _____ Date: 11/15/08

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #11-A and 11-B – Medical condition

If you answered "yes" to Questions 11-A or 11-B, please set forth the specifics of your condition and any related treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than three (3) months prior to the date of your application. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

QUESTION #12-A – Use of chemical substances

If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of your treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of chemical substances on your current practice, including participation in any supervised rehabilitation program or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than thirty (30) days prior to the date of your application. You must also arrange for the appropriate institutions to submit all discharge summaries regarding any alcohol or drug dependency directly to the Board. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

Signature: _____ Date: 11/15/09

PRINT NAME: Christ-Ann Magwire MD

QUESTION #12-B – Refusal to take screening test

If you answered "yes" to Question #12-B, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

QUESTION #13 – Illegal use or misuse of drugs

List chemical substances:

Describe frequency of usage:

Please note that additional information may be requested by the Board.

QUESTION #14 – Voluntary modification of scope of practice

Describe circumstances leading to modification of practice:

Describe modification of practice

Dates: From: ___/___/____ To: ____/____/____

Please note that additional information may be requested by the Board.

Signature: Date: 11/15/08

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

MALPRACTICE HISTORY

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

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

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

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: Nassau Health Care Corporation, Ltd. c/o AON Insurance Managers (Cayman) Ltd. From: 7/99 To: 6/01
City: Georgetown, Grand Cayman State: BWI Policy Number: 001-01

Liability Carrier: Triton Group - Federal Tort Claims Act From: 9/03 To: Present
City: _____ State: _____ Policy Number: _____

Liability Carrier: Boston Medical Center, LTD From: 6/01 To: 6/03
City: Boston State: MA Policy Number: _____

Applicant's signature: _____ 11/15/08 Date

Print Name: Christ-Ann Laplante MD

Address: 1411 W. Oakmont Drive City: Miami

State: Florida Zip code: 33015

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MALPRACTICE HISTORY

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

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: RMCLC From: 6/30/02 To: 6/30/03
City: Grand Cayman State: Cayman Islands Policy Number: RMCLC-PR-A-02

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Applicant's signature: _____ 9/11/08 Date

Print Name: Christ-Ann Mayforth MD

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

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MALPRACTICE HISTORY

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

Waiver for Release of Information

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

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

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: HRSA-FCTA Tort Act (Federal Claims) From: 01/01/2008 To: 12/31/2008
City: See Attached State: _____ Policy Number: _____

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

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

Applicant's signature: _____ 9, 30, 08 Date

Print Name: Christ-Ann Mastrire, MD

Address: _____ City: _____

State: _____ Zip code: _____

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MALPRACTICE HISTORY

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

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

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

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

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

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

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

Applicant's signature: _____ 9/11/08 Date

Print Name: Christ-Ann Kaplanke MD

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Christ-Ann A Magloire, M.D. **License No.:** 212521

Current Status: Active **License Expiration Date:** 11/5/2009

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:
2316 Hollywood Boulevard
Hollywood
Florida - 33020
United States of America
(305) 757-2517

3) Email Address:

4) Fax Number: (305) 757-2517

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
None Reported

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
	None Reported

Physician Name: Christ-Ann A Magloire, M.D. **License No.:** 212521

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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?

Physician Name: Christ-Ann A Magloire, M.D. **License No.:** 212521

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: Christ-Ann A Magloire, M.D. **License No.:** 212521

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.**

212521

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

11/7/2011

11/7/2011

Christ-Ann A Magloire M.D.

LICENSE EXPIRATION DATE: 11/5/2011 LICENSE # 212521

Dear Dr. Magloire :

Please be advised that your license to practice medicine is now lapsed and you cannot practice medicine in the Commonwealth of Massachusetts unless you revive your license.

If you wish to revive your license, you must complete a lapsed license application which is available at the Board's website at www.mass.gov/massmedboard or by request from the Board. Your license revival must be approved by the full Board. The fee for revival of your license is $700.00 and the term of your license period will extend until your next birthday. At that time, you would be required to submit a complete standard two-year license renewal application.

Practicing medicine with an expired license is a criminal offense and in violation of M.G.L.c.112 §5 and the Board's regulation 243 CMR 1.05(5). Physicians who engage in the practice of medicine with an expired license must be reported to the Attorney General and may be subject to disciplinary action by the Board.

If you have any questions about these procedures, please call the Licensing Division at (781) 876-8210.

Sincerely,

Rose M. Foss

Rose M. Foss, Director
Licensing Division

CERTIFIED MAIL, RETURN RECEIPT REQUESTED