Application #: _____

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

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

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

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

Lefkowitz	Janet	Beth	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

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

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: ____ ____ ____ Social Security Number: _____ _____
Month Day Year

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

*Mailing Address: _____ Telephone: _ ___
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: 166 Toll Gate Road Telephone: (401) 738-6031
Number and Street

Warwick	RI	02886
City	State/Province/Territory	Zip (or postal) Code

E-mail Address: _____ Fax number: 401.732.7842

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

*** The Board will use your Mailing Address for all correspondence**

Date Received: 4/10/12

Check #: 5226

Check Amount: $ 600

Initials: _____

Pre-medical School

			From	To
Facility: Sarah Lawrence College	Degree: BA		09/__/83	05/__/87
Street: 1 Mead Way	City: Bronxville	State: NY		
Facility: Columbia University	Degree: Post-Bach		09/__/94	05/__/96
Street: 535 West 116th Street	City: New York	State: NY		

Medical School

			From	To
Facility: University of New England College of Osteopathic Medicine	Degree: DO		09/__/98	05/__/01
Street: 11 Hills Beach Road	City: Biddeford	State: ME		
Facility:	Degree:		__/__/__	__/__/__
Street:	City:	State:		

Date of medical school graduation: 05 / 2001
Month Year

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 in chronological order from medical school to the present. Include 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: Delaware County Memorial Hospital	Position: Intern		06/__/01	06/__/02
Street: 501 North Lansdowne Avenue	City: Drexel Hill	State: PA		
Facility: St. Francis Hospital	Position: PGY 1-4		07/__/02	06/__/06
Street: 114 Woodland Street	City: Hartford	State: CT		
Facility:	Position:		__/__/__	__/__/__
Street:	City:	State:		
Facility:	Position:		__/__/__	__/__/__
Street:	City:	State:		
Facility:	Position:		__/__/__	__/__/__
Street:	City:	State:		

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I		☐ P	☐ F	
USMLE Step II		☐ P	☐ F	
USMLE Step III		☐ P	☐ F	
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part 1		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1	06/01/99	☒ P	☐ F	1
COMLEX Level 2	03/06/01	☒ P	☐ F	1
COMLEX Level 3	12/09/03	☒ P	☐ F	3
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

Hospital Affiliations and Employment

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

		From	To
Facility: Kent County Hospital	Position: Attending Physician	08/__/06	Present/__
Street: 455 Toll Gate Road	City: Warwick	State: RI	
Facility: Women & Infants Hospital	Position: Attending Physician	08/__/06	Present/__
Street: 101 Dudley Street	City: Providence	State: RI	
Facility: Caring for Women	Position: OB/GYN Priv. Practice	08/__/06	Present/__
Street: 166 Toll Gate Road	City: Warwick	State: RI	
Warren Alpert Medical School of Brown University			
Facility: Women and Infants Hospita	Position: Clinical Instructor	09/__/10	Present/__
Street: 101 Dudley Street	City: Providence	State: RI	

1. List other states (abbreviations) where you are currently or have ever had a full license: RI ____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): N/A Certification date: ____/____/____

   ____ Certification date: ____/____/____

4. List your practice specialt(ies) OB/GYN

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page?) ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: Camp Doctor

7. Name of Facility: Camp Eisner

   Address: 53 Brookside Road City: Great Barrington

8. Anticipated starting date in Massachusetts: 07 / 23 / 12

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full 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 a full 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 of Applicant

4 / 3 / 12
Month Day Year

(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 purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: | 1 | 2 | 3 | 5 | 1 | 4 | 9 | 8 | 6 | 5 |

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.

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

Signature: _____ Date: 4/3/12

Janet B. Lefkowitz, DO

March 29, 2012

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

Dear Board of Registration in Medicine:

Enclosed is my application and supporting documents for medical licensure. Requests for direct verification of my credentials have been processed.

I have engaged the services of Medical Licensure Group to assist with the licensure process and hereby authorize the Board of Registration in Medicine to release any and all correspondence (including but not limited to acknowledgement letters, online login information, deficiency notices, etc.) related to the processing of my application.

Please direct all correspondence to:

Medical Licensure Group
Attn: Stephen Densmore
1010 N. 12th Ave, Suite 133
Pensacola, FL 32501
Phone: 850.433.4600
Fax: 904.212.0886
sdensmore@medicallicensuregroup.com

Thank you for your consideration.

Cordially,

Janet B. Lefkowitz, DO

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

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. Someone who has known you for a substantial period of time and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH

Signature of applicant

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

Signature of Notary

March 30, 2013
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Janet B. Lefkowitz, DO
(name of applicant)

for 10 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 Certifying Physician

MA 236470 — License Number
4/5/12 — State

Timothy Spurrell MD
Type or print name clearly

Address: 166 Tollgate Road
City: Warwick
State: RI Zip: 02886
Telephone: (401) 739-2000
Date: 4/5/12

***Instructions to the certifying physician**: Return the completed form to the applicant in a sealed envelope with your signature across the seal.*

Seal Verified
DATE: 4/11/2012
INITIALS:

Janet Lefkowitz

phone:
email:

EMPLOYMENT

Obstetrician and Gynecologist
Caring for Women
166 Tollgate Road
Warwick, RI 02886
July 2006 – present

Attending Staff Physician
Kent County Hospital
Warwick, RI 02886
July 2006 - present

Women & Infants Hospital
Providence, RI 02905
July 2006 – present

EDUCATION

GRADUATE MEDICAL EDUCATION

Obstetrics & Gynecology Residency
St. Francis Hospital and Medical Center
Hartford, CT 06105
July 2002 – June 2006

Rotating Internship
Delaware County Memorial Hospital/Crozer Keystone Health System
Drexel Hill, PA 10296
June 2001 - June 2002

MEDICAL SCHOOL

University of New England College of Osteopathic Medicine
Biddeford, Maine
Doctor of Osteopathic Medicine
June 2001

UNDERGRADUATE

Columbia University
New York, NY
Pre-Med Program
1994 – 1996

Sarah Lawrence College
Bronxville, NY
B.A. Liberal Arts, 1987
1983 – 1987

Wadham College
Oxford University, England
Study Abroad
1985 - 1986

MEDICAL EXPERIENCE

CLINICAL INSTRUCTOR in OBSTETRICS and GYNECOLOGY
Warren Alpert Medical School of Brown University
Women and Infants Hospital – Department of Obstetrics and Gynecology
September 2010 – present

MEMORIAL SLOAN KETTERING CANCER CENTER, NYC
Biochemical Immunogenetics Laboratory Research Technician
Primary responsibility was the typing of DNA for HLA for the National Bone Marrow Donor Program.
June 1996 - February 1997

In-house Temporary Medical Secretary/Assistant
Worked in several services including urology and gastroenterology.
February 1997 - June 1997

MOUNT SINAI HOSPITAL - WOMEN'S HEALTH CENTER, NYC
Volunteer
Assisted in an investigational drug study sponsored by the Eli Lilly Corporation. Study was for Raloxifene, a hormone replacement therapy drug. Monitored its effects on bone, endometrium, menopausal symptoms and lipids on early post-menopausal women.
Sept. 1995 - June 1996

ST. VINCENT'S HOSPITAL - NYC
Emergency Room Patient Representative and Volunteer at OB/GYN clinic
Jan. 1995 - June 1996

MEMBERSHIP

Rhode Island Society of Osteopathic Physicians & Surgeons	2006 - present
New England Obstetric and Gynecology Society	2006 - present
UNECOM Alumni Association	2006 - present
American College of Obstetricians and Gynecologists	
Junior Fellow	2002 - present
American Osteopathic Association	1996 - present

AWARDS AND RECOGNITION

Top Community-based Faculty Teacher of the Year Award
Resident Medical Education 2010 - 2011
Warren Alpert Medical School of Brown University
Women and Infants Hospital – Department of Obstetrics and Gynecology

AWARDS AND RECOGNITION continued

Excellence in Teaching Award — 2009 - 2010
Warren Alpert Medical School of Brown University
Women and Infants Hospital – Department of Obstetrics and Gynecology

Excellence in Teaching Award — July 2007
Warren Alpert Medical School of Brown University
Women and Infants Hospital – Department of Obstetrics and Gynecology

APPOINTMENTS

Quality Improvement Committee — 2010 - present
Kent County Hospital
Warwick, RI 02886

Treasurer – Department of Obstetrics and Gynecology — 2009 - present
Kent County Hospital
Warwick, RI 02886

CareLINK Physician Advisory Group — 2005 - 2006
St. Francis Hospital & Medical Center

Histology Teaching Assistant — 1998 - 1999
Revised/Edited 1998 - 1999 Histology Manual
UNECOM

OMM Teaching Assistant — 1998 -1999
UNECOM

Freshman Orientation Committee — 1998
UNECOM

Resident Advisor — 1984 -1985
Sarah Lawrence College

ELECTED POSITIONS

Vice-President, ACOFP - UNECOM — 1998 - 1999

Jewish Campus Union (JCU) - UNECOM
Vice-President/Founding Member — 1997 - 1998
Secretary — 1998 - 1999

Senior Class President
Sarah Lawrence College — 1986 - 1987

Co-Captain and Founding Member — 1986 - 1987
Sarah Lawrence Rowing Team

TEACHING ACTIVITIES (posters, courses, presentations, lectures) - available on request

OTHER EXPERIENCE - available on request

COMMUNITY SERVICE - available on request

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Janet B. Lefkowitz, DO
(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

4/3/12
Date of Signature

Lefkowitz, Janet B.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Janet Lefkowitz

phone:
email:

EMPLOYMENT

Obstetrician and Gynecologist
Caring for Women
166 Tollgate Road
Warwick, RI 02886
July 2006 – present

Attending Staff Physician
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UNECOM

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UNECOM

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UNECOM

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COMMUNITY SERVICE - available on request

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

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.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: _____ Date of Birth _____

Print or Type Name: LEFKOWITZ (Last name) JANET (First Name) B (Middle Initial) Social Security No:

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

Name of Medical School: UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE

Address: STELLA MARIS HALL 11 HILLS BEACH ROAD City: BIDDEFORD State or Province: MAINE 04005

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it 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: COLUMBIA UNIVERSITY / SARAH LAWRENCE COLLEGE

Undergraduate School Address: NEW YORK

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that LEFKOWITZ JANET B.

(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
	09/05/97	07/03/98	08/02/00	06/02/01
	08/03/98	07/16/99	/ /	/ /
	08/02/99	06/30/00	/ /	/ /

The applicant attended 160 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one

☑ was awarded a degree in Doctor of Osteopathic Medicine on (month/day/year) 06/02/01

☐ 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: Joan M. Monahan

Print Name: Joan M. Monahan

Title: Registrar

Date: 3/13/12 Telephone: (207) 283-0171

E-mail address: unereg1strar@une.edu

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

Seal Verified

DATE: 5-23-12

INITIALS: KY

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4606 F 617-638-4905
www.bu.edu/cme

BOSTON UNIVERSITY

Janet Lefkowitz, DO
32 Lawton Avenue
North Kingstown, RI 02852

Boston University School of Medicine

certifies that

Janet B. Lefkowitz, DO

has participated in the educational material titled

Opioid Efficacy and Safety & Assessment and Monitoring Tools

The activity was designated for 1.00 *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 16th, 2012
Maximum Credits: 1

Score: 100

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *1 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of risk management study.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of opioid education.

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4805 F 617-638-4905
www.bu.edu/cme

BOSTON UNIVERSITY

Janet Lefkowitz, DO
32 Lawton Avenue
North Kingstown, RI 02852

Boston University School of Medicine

certifies that

Janet B. Lefkowitz, DO

has participated in the educational material titled

Case Study

The activity was designated for **1.00** *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 19th, 2012
Maximum Credits: 1

Score: 75

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *1 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of risk management study.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of opioid education.

Barry M. Manuel, M.D.

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4605 F 617-638-4905
www.bu.edu/cme

BOSTON UNIVERSITY

Janet Lefkowitz, DO
32 Lawton Avenue
North Kingstown, RI 02852

Boston University School of Medicine

certifies that

Janet B. Lefkowitz, DO

has participated in the educational material titled

Communicating with Patients & Managing Patients with Psychiatric Comorbidities

The activity was designated for 1.00 *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 19th, 2012
Maximum Credits: 1

Score: 100

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *1 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of risk management study.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1 hour of opioid education.

Barry M. Manuel, M.D.

Barry M. Manuel, M.D.
Associate Dean

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, Janet B. Lefkowitz, DO (type or print name),

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

SIGNED: _____ DATE: 4/3/12

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: 4/3/12

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

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: Women & Infants Indemnification Program **From:** 08 / 08 **To:** 06 / 12
City: Providence State: RI Policy Number: WIH/311

Liability Carrier: St. Francis Hospital Risk Management **From:** 07 / 02 **To:** 06 / 06
City: Hartford State: CT Policy Number: Unknown

Liability Carrier: Delaware County Memorial Hosp Risk Mgmt **From:** 06 / 01 **To:** 06 / 02
City: Drexel Hill State: PA Policy Number: Unknown

Applicant's signature: _____ 4/3/12 Date

Print Name: Janet B. Lefkowitz, DO

Address: _____ City: _____

State: _____ Zip code: _____

MALPRACTICE HISTORY

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

MALPRACTICE HISTORY

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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.

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City: Hartford State: CT Policy Number: Unknown

Liability Carrier: Delaware County Memorial Hosp Risk Mgmt From: 06 / 01 To: 06 / 02
City: Drexel Hill State: PA Policy Number: Unknown

Applicant's signature: SEE RELEASE ____/____/____
Date

Print Name: Janet B. Lefkowitz, DO

Address: _____ City: _____

State: _____ Zip code _____

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

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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: W+I Hospital From: ___/___ To: ___/___
City: Roudoux State: RI Policy Number: _____

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

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

Applicant's signature: _____ ___/___/___
Date

Print Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

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

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City: Hartford State: CT Policy Number: Unknown

Liability Carrier: Delaware County Memorial Hosp Risk Mgmt **From:** 06 / 01 **To:** 06 / 02
City: Drexel Hill State: PA Policy Number: Unknown

Applicant's signature: SEE RELEASE ____/____/____
Date

Print Name: Janet B. Lefkowitz, DO

Address: _____ City: _____

State: _____ Zip code: _____

MEDICAL LICENSURE GROUP
1010 N 12TH AVE, STE 133
PENSACOLA, FL 32501

RELEASE AND AUTHORIZATION

I, JANET LEFKOWITZ, hereby acknowledge that I have retained the service of Medical Licensure Group and its appointed agents to carry out its duties in accordance with my request for a license to practice medicine in the United States.

To those ends, I hereby authorize all hospitals, clinics, medical institutions, medical societies, medical organizations, personal references, employers, specialty boards, business and/or professional colleagues, medical licensure boards, high school and university transcript offices, test score reporting centers, medical schools, malpractice insurance companies, and attorneys who have participated in civil or criminal actions in which I was named party that pertain to or directly affect my ability to obtain or retain a state medical license and/or practice medicine, to release to the state medical licensing board and/or Medical Licensure Group and its authorized agents any information, files or records, required by that particular state medical licensing board for its evaluation of my professional, educational, ethical, and physical qualifications for medical licensure.

I hereby release the above-mentioned individuals and entities from all liability for the release of information to the state medical licensing board or its agents.

A PHOTOCOPY OR FAX OF THIS RELEASE SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Signature: Janet Lefkowitz Date: 3/22/12

MEDICAL LICENSURE GROUP

...the licensing resource for busy physicians

April 11, 2012

Delaware County Memorial Hospital
Risk Management:
Tel: 610-284-8156
Fax: 610-447-2660
Attn: Paula Trumbauer

RE: Request for Malpractice Insurance Verification and Claims History Report

Physician: Janet B. Lefkowitz, DO	Date of Birth:
Social Security Number:	

To Whom It May Concern:

We are assisting the above referenced physician in applying for a medical license in the state of Massachusetts. To facilitate the process, please complete the attached form and provide a claims history report (See instructions on attachment).

Dr. Lefkowitz was a Traditional Rotating Intern from 06/01 – 06/02.
6/2001 - 6/24/02

Mail the originals to the following address:

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

RECEIVED
APR 24 2012
Board of Registration in Medicine

Upon completion, please send an e-mail to sdensmore@medicallicensuregroup.com with mailing confirmation.

Cordially,

Stephen Densmore
Licensing Specialist

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 3/16/12

Print or Type Name: JANET LEFKOWITZ

Name of Institution: DELAWARE COUNTY/CROZER-KEYSTONE HEALTH SYSTEM

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal.** If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: DELAWARE COUNTY MEMORIAL HOSPITAL, CROZER-KEYSTONE HEALTH SYSTEM

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

Enrollment and Participation: Our records indicate that JANET LEFKOWITZ, DO participated in the following program:
(Print applicant's name)

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
TRADITIONAL OSTEOPATHIC ROTATING INTERNSHIP	1	OSTEOPATHIC	6/25/2001	6/23/2002	YES	AOA

(Continued on page 2)

APPLICANT'S NAME: JANET LEFKOWITZ

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 [X] was accredited by: [ ] ACGME [X] Other: AOA

COMMENTS: _____

_____

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

AFFI[illegible]AL

(If the [illegible] this fo[illegible]y public).

Program Director's Signature: Christine F Giesa DO

Print Name: Christine F. Giesa, DO, FACOEP-d

Academic Title: Director, Osteopathic Medical Education

Crozer-Keystone Health System
Delaware County Memorial Hospital
501 N. Lansdowne Avenue
Drexel Hill, PA 19026-1186

Telephone: (610) 284-8230 Today's Date: 3/20/2012

E-mail address: _____

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 4/11/2012
INITIALS: dmg

OSTEOPATHIC INTERN ROTATION SCHEDULE 01-02
Delaware County Memorial Hospital

INTERN	6/25/01 7/22/01	7/23/01 8/19/01	8/20/01 9/16/01	9/17/01 10/14/01	10/15/01 11/11/01	11/12/01 12/9/01	12/10/01 1/6/02	1/7/02 2/3/02	2/4/02 3/3/02	3/4/02 3/31/02	4/1/02 4/28/02	4/29/00 5/26/02	5/27/02 6/23/02
LEFKOWITZ Janet	**OB/ GYN #2**	**RAD/ ONC #2**	**ORTHO**	**ELECT OB/GYN Out of CKHS**	**T**	**ELECT OB/GYN Out of CKHS**	**ELECT x 4 OBGYN Out of CKHS**	**3M**	**FP**	**ER #2**	**ELECT Card x2/ VACA**	**PEDS**	**CCMC MED**

Spring Card (Cardiology –Springfield Hospital)
ER – DCMH
FP – DCMH
PEDS – Crozer Chester Medical Center
OB/GYN – Crozer Chester Medical Center
SS (Gen. Surg.-Springfield Hospital)
Crozer Chester Medical Center – Medicine
Rad/Onc – DCMH
3 M – General Surgery DCMH
T - Trauma – Crozer Chester Medical Center
Ortho - DCMH

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: See Release Date: 05/29/12

Print or Type Name: Janet B. Lefkowitz, DO

Name of Institution: St. Francis Hospital

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: St Francis Hospital and Medical Center. If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Janet Lefkowicz, DO (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
~~Internship/Residency~~	~~PGY 1-4~~	~~OB/GYN~~			Yes	~~yes~~
OB/Gyn Internship	1	ob/gyn	7/1/02	6/30/03	yes	ACGME
Residency	2	ob/gyn	7/1/03	6/30/04	Yes	ACGME
Residency	3	ob/gyn	7/1/04	6/30/05	Yes	ACGME
Residency	4	ob/gyn	7/1/05	6/30/06	Yes	ACGME

(Continued on page 2)

APPLICANT'S NAME: Janet B. Lefkowitz, DO

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 by a notary public).

Program Director's Signature: Mark Wolf

Print Name: Mark Wolf

Academic Title: Program Director

Telephone: (860) 714-5170 Today's Date: 5/30/2012

E-mail address: MWolf@stfranciscare.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 6-5-12
INITIALS: KY

RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

FULL LICENSE VERIFICATION

****

PHYSICIAN:	**JANET BETH LEFKOWITZ, DO**
DATE OF BIRTH:	
LICENSE NUMBER:	**DO00607**
DATE ISSUED:	**04/25/2006**
LICENSE STATUS:	**Active**
EXPIRATION DATE:	**06/30/2012**
MEDICAL SCHOOL:	**University of New England Coll. of Osteopathic Med**
GRADUATION YEAR:	**2001**
EXAM:	**National Boards - National Boards III**

This license information was last updated on: 04/11/2012

****

This is to certify that the above-named physician is licensed to practice medicine in the State of Rhode Island. There have been no disciplinary actions taken against this physician's license.

Lauren Lasso
Medical License Coordinator
Board of Medical Licensure & Discipline

April 11, 2012

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

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: 3/14/12

Print or type name: JANET LEFKOWITZ

License number: D0006907 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: ___/___/___

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

SUPPLEMENT FORM

PRINT NAME: Janet B. Lefkowitz, DO DATE: ____/____/____

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. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation or remediation by a medical school or any postgraduate training program?		
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
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: any Step of the USMLE, NBOME, FLEX, any State Board examination, any part of the National Boards, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body 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 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)?		

Applicant's Signature: _____ Date: 4/3/12

		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 termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid; or have you ever been restricted from receiving payments from any Medicare, Medicaid (any state), or third party payors?		
14.	Have you ever had an application for membership as a participating provider rejected by any third-party payor?		
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 or has such a suit been settled, adjudicated or otherwise resolved?		
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:** 4/13/12

CONFIDENTIAL 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 supplemental pages for questions #16 to 18. 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.	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?		
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?		

If your responses to Questions 1-18 change while your application is pending, you must immediately notify the Board of the new information.

Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that 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 certification does not imply that you will participate in the Medicare program).

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.

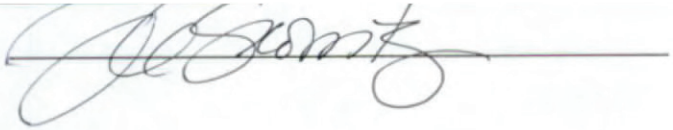
I certify under the penalties of perjury that all information on this form (front and back, and all attached pages) is true, to the best of my knowledge.

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.

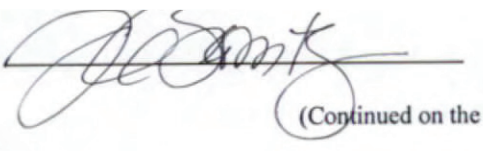
Applicant's Signature: _____ Date: 4/3/12

Signature: _____ Date: 4/3/12

PRINT NAME: Janet B. Lefkowitz, DO

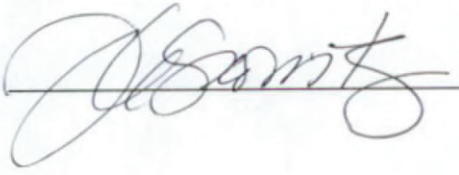
Signature:  Date: 4/3/12

Signature: _____ Date: 4/3/12

Signature:  Date: 4/3/12

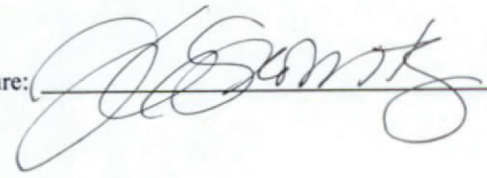
(Continued on the next page)

NOTE: Please be advised that the Board may request permanent medical records of the patient.

Signature:  Date: 4/3/12

CONFIDENTIAL MEDICAL INFORMATION

Signature: _____ Date: 4/3/12

Signature:  Date: 4/3/12

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Janet B Lefkowitz, D.O. **License No.:** 251954

Current Status: Active **License Expiration Date:** 4/17/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
166 Toll Gate Road
Warwick
Rhode Island - 02886
United States of America
(401) 738-6031

3) **Email Address:**

4) **Fax Number:** (401) 732-7842

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**
Rhode Island

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

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.

Other

I will be the camp physician for a portion of the summer at Eisner Camp in Great Barrington, MA. During that time I will be covered by the camp's malpractice insurance.

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, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

Physician Name: Janet B Lefkowitz, D.O. **License No.:** 251954

20)	**Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?**	
21)	**Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?**	
22)	**Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)**	Yes

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: Janet B Lefkowitz, D.O. **License No.:** 251954

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: Georgia Composite Medical Board

ADDRESS: 2 Peachtree Street, NW, 36th floor

CITY: Atlanta STATE: GA ZIP: 30303

(TYPE OR PRINT)
PHYSICIAN'S NAME: Janet B. Lefkowitz, DO

BUSINESS ADDRESS: 166 Toll Gate Road

CITY: Warwick STATE: RI ZIP: 02886

MASSACHUSETTS LICENSE NUMBER: 251954

SIGNATURE OF PHYSICIAN: _____
Signed under the penalties of perjury

DATE: 05/02/2013

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

Date Received: 5/7/13
Check #: 10459
Check Amount: $

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Janet B Lefkowitz, D.O. **License No.:** 251954

Current Status: Active **License Expiration Date:** 4/17/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
105 Collier Road, Suite 1010
Atlanta
Georgia - 30309
United States of America
(404) 355-4885

3) **Email Address:**

4) **Fax Number:**

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**
Georgia
Ohio
Rhode Island

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

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

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Doctors Co	08/01/2014	08/01/2015	Claims made with tail coverage

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 taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

Physician Name: Janet B Lefkowitz, D.O. **License No.:** 251954

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, 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?

Physician Name: Janet B Lefkowitz, D.O. **License No.:** 251954

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.**

251954

Morelli, Charlene (MED)

From: Janet Lefkowitz <[redacted]>
Sent: Wednesday, March 18, 2015 2:42 PM
To: Morelli, Charlene (MED)
Subject: RE: Board of Registration in Medicine

Thank you. I thought I had changed my address when filling out the renewal online. My new and updated address is

[redacted]

Please send my license to that address. Thanks again for your help.
Janet Lefkowitz

Sent via the Samsung GALAXY S® 5, an AT&T 4G LTE smartphone

-------- Original message --------
From: "Morelli, Charlene (MED)" <charlene.morelli@state.ma.us>
Date:03/18/2015 2:15 PM (GMT-05:00)
To: [redacted]
Subject: Board of Registration in Medicine

Dear Doctor Lefkowitz:

RE: License No. 251954

Your medical license was returned to the Board. The address you gave us to mail your license was [redacted]. Where do you want your license mailed?

Thank you,

Charlene Morelli

Renewals Coordinator

Licensing Division

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

ɛtion of this waiver will authorize the release of information from the Board of ion files to the entity listed below. This waiver form must be properly executed and vaiver form is acceptable.

released pursuant to this waiver is based entirely on review of open and closed les and does not include information in the license application, renewal application nentation that the Board of Registration is required to obtain by statute, e.g. court nsurance verifications and information from health care entities.

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Alabama Board of Medical Examiners

ADDRESS: P.O. Box 946

CITY: Montgomery STATE: AL ZIP: 36101

(TYPE OR PRINT)
PHYSICIAN'S NAME: Janet B. Lefkowitz, DO

BUSINESS ADDRESS: 105 Collier Road NW #1010

CITY: Atlanta, STATE: GA ZIP: 30309

MASSACHUSETTS
LICENSE NUMBER: 251954

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

DATE: 06/02/2016

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

Date Received: 6/8/16
Check #: 17292
Check Amount: $ 10.00
Initials: CM

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: Mississippi State Board of Medical Licensure

ADDRESS: 1867 Crane Ridge Drive, Suite 200-B

CITY: Jackson STATE: MS ZIP: 39216

(TYPE OR PRINT)
PHYSICIAN'S NAME: Janet B. Lefkowitz, DO

BUSINESS ADDRESS: Atlanta Minimally Invasive Gynecologic Surgery

CITY: Atlanta STATE: GA ZIP: 30309

MASSACHUSETTS LICENSE NUMBER: 251954

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: 8/19/2016

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

Date Received: 8/24/16
Check #: 18151
Check Amount: $ 10.00
Initials: CM

Date Received: 8/8/18
Check #: 4963
Check Amount: $ 10.00
Initials: RF

RECEIVED
AUG 08 2018
Board of Registration in Medicine

Commonwealth of Massachusetts

Board of Registration in Medicine

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

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: State of Florida Board of Osteopathic Medicine

ADDRESS: 4052 Bald Cypress Way, #C-06

CITY: Tallahassee STATE: FL ZIP: 32399

(TYPE OR PRINT)
PHYSICIAN'S NAME: Janet B. Lefkowitz, DO

BUSINESS ADDRESS: 105 Collier Road NW #1010

CITY: Atlanta, STATE: GA ZIP: 30309

MASSACHUSETTS LICENSE NUMBER: 251954

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: 07/31/2018

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

Board of Registration in Medicine – Licensing Division

Today's Date: 07/31/2019

Dear Doctor Lefkowitz:

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90 day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday is September 1, 2015 and your license is issued on July 1, 2015, your renewal date will be September 1, 2016. However, if your birthday is September 1, 2015 and your full license is issued on January 1, 2016, you will have to renew your license on September 1, 2016. Renewals thereafter will be on a two-year birthday cycle.

Sincerely,

Licensing Division

Please select one of the boxes below, sign and date this form and return it to the Licensing Analyst.

☒ Do not hold my full application; send it to the Board as soon as it is completed.

☐ Hold my full application until it is within the 90 day time period

My birthdate is ____ ____ ____

Signature: _____ Date: 8/1/19

s/licensing/forms.birthdayrenewal.2.03.2011

August 1, 2019

To the Massachusetts Board of Registration –

Please know that in October 2013 I moved to Atlanta, GA as my husband's job took us there. After a few months of helping to get my family settled in our new community, I continued (and continue) my work in OB/GYN, inclusive of being a staff physician, in private practice with admitting privileges at a large regional health system. When the renewal for my Massachusetts license came about in 2017, I was fully engaged in my work here in the south, not anticipating that my circumstances would change again. I did not renew my Massachusetts license at that time. Then in October of 2018, my husband started a new job in Massachusetts. And while we have considered a "commuting" situation, my decision is to join my husband in Massachusetts, and to re-establish myself professionally there.

Thank you for your consideration,

Janet Lefkowitz

APPLICANT'S NAME: Janet B. Lefkowitz, DO

MA License Number: 251954
Date license revived: ____/____/____

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

LAPSED LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $700.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

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

Lefkowitz	Janet	Beth	
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: ___ ___ ___ ___ ___ ___ ___ ___ ___

National Provider Identifier (NPI) Number 1235149865

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: 1968 Peachtree St NW
Number and Street

Atlanta,	GA	30309
City	State/Province/Territory	Zip (or postal) Code

Business Telephone: (404) 355 - 4885 , ext. _____

Home Telephone: (____)_____

E-mail Address: _____

Fax Number: _____

Preferred Mailing Address: ☐ Business Address ☑ Home Address

Date Received: 7/22/19

Check #: 8832

Check Amount: $ 700.00

Initials: AF

APPLICANT'S NAME: Janet B. Lefkowitz, DO

Postgraduate Education

List in chronological order all postgraduate training 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: Delaware County Memorial Hospital	Position:	Traditional Rotating Internship	06 / 01 / 2001	06 / 30 / 2002
Street: 501 North Lansdowne Avenue	City:	Drexel Hill,	State:	PA
Facility: St. Francis Hospital	Position:	OB/GYN Internship Residency	07 / 01 / 2002	06 / 30 / 2006
Street: 114 Woodland Street	City:	Hartford,	State:	CT
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: Kent County Hospital	Position:	Attending Physician	08 / 01 / 2006	06 / 30 / 2016
Street: 455 Toll Gate Road	City:	Warwick,	State:	RI
Facility: Women & Infants Hospital	Position:	Attending Physician	08 / 01 / 2006	06 / 30 / 2016
Street: 101 Dudley Street	City:	Providence,	State:	RI
Facility: Caring for Women	Position:	OB/GYN Private Practice	08 / 01 / 2006	12 / 31 / 2013
Street: 166 Toll Gate Road	City:		State:	
Facility: Warren Alpert Medical School of Brown University	Position:	Clinical Instructor in OB/GYN	09 / 01 / 2010	06 / 30 / 2016
Street: Women and Infants Hospital 101 Dudley Street	City:	Providence,	State:	RI
Facility: Atlanta Minimally Invasive Gynecologic Surgery	Position:	Attending Physician	10 / 01 / 2014	PRE/SEN / T
Street: 105 Collier Road NW #1010	City:	Atlanta,	State:	GA
Piedmont Hospital 1968 Peachtree St NW		Attending Physician Atlanta,	10/ 01 / 2014	Present GA

APPLICANT'S NAME: Janet B. Lefkowitz, DO

Medical Malpractice Information

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

Print name of insurer: THE DOCTORS COMPANY

Policy dates: From: 8/1/14 To: PRESENT

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 Professional Development (CPD) (formerly Continuing Medical Education)

Read instructions for CPD requirements on page 3 before completing.

Activity status: ☒ Active ☐ Exemption

Category 1 credits 100 Risk Management Category 1 10
Category 2 credits Risk Management Category 2

Continuing Professional Development credit requirements must be completed before the lapsed license can be revived.

1. You must complete training to recognize and report suspected child abuse or neglect. Have you completed the required training? (See instructions.) ☒ Yes ☐ No (Your license will not processed until you complete the required training.)

2. List other states (abbreviations) where you are currently or have ever been licensed: RI PA CT MA GA MS FL OH AL

3. A. Are you certified by the American Board of Medical Specialties (ABMS)? ☑ Yes ☐ No
   B. Are you certified by the American Osteopathic Association (AOA)? ☐ Yes ☑ No

4. List only ABMS certification(s): American Board of Obstetrics and Gynecology - OB/GYN

5. Reason for requesting revival of lapsed license in Massachusetts:
   MOVING BACK TO THE NORTHEAST, AND PLAN TO RESIDE + WORK IN MASSACHUSETTS

6. **Please attach your current curriculum vitae listing the months and years of education, training, clinical activity and work history since your graduation from medical school.**

APPLICANT'S NAME: Janet B. Lefkowitz, DO

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 pains and penalties of perjury, I declare that I have examined this Lapsed License Application and all of its accompanying instructions, forms and statements, and, to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature: _____ Date: 4/10/19 4/12/19

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

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Janet B. Lefkowitz, DO
(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

4/10/19
Date of Signature 4/12/19 jr

Lefkowitz, Janet, B
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 it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, Janet B. Lefkowitz, DO ,
(type or print name)

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

SIGNED: _____ DATE: 4/10/19
7/12/19 JL

Social Security Number: _____

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) 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: 4/10/19
7/12/19 JL

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

___ Participation in a Meaningful Use program as an eligible professional;
☒ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
___ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
___ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

___ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4); or
___ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: _____ DATE: 4/10/19
7/12/19

Janet Lefkowitz, DO, FACOG

EMPLOYMENT

Chief Medical Officer **April 2016 - Present**
Planned Parenthood Southeast, Atlanta, GA
Responsible for hiring, community relations, orientation, education, privileging, quality, and performance for all licensed clinical staff across all clinics in Alabama, Georgia and Mississippi. Direct provision of patient care and consultation with clinicians including direction of all specialized services. Accountable for internal audits, medical records, accreditation reviews, and medical standards and guidelines.

- Increased clinical staffing by over 20% during a time of low unemployment and a charged political environment.
- Led clinical staff and senior staff to bring all clinics to full accreditation status.
- Accountable to state regulatory bodies in three states as the Medical and Lab Director of-record.

Gynecologist **October 2014 – Present**
Atlanta Minimally Invasive Gynecologic Surgery, Atlanta, GA
Provide wide range of reproductive health service in private gynecologic practice. Treat patients in clinical, hospital and surgical settings. Participate in inter-practice call coverage group of five physicians.

Attending Staff Physician **October 2014 – Present**
Piedmont Hospital and Piedmont Clinic, Atlanta, GA
Part of Piedmont Clinic staff. Graduate of the Piedmont Leadership Academy. Provide hospital on-call coverage. Participated in Grand Rounds for the Women's Health & OB/GYN Services Department.

Obstetrician and Gynecologist **March 2014 – March 2016**
Locum Tenens / Independent Contractor, Various Locations
Provided obstetric and gynecologic care in hospital settings on a per diem basis in Rhode Island and Ohio. Covering attending physician in teaching hospital to assist in resident training.

Obstetrician and Gynecologist **August 2006 – October 2013**
Caring for Women, Warwick, RI
Provided wide range of reproductive health service in private obstetric and gynecologic practice. Treated patients in clinical, hospital and surgical settings. Participated in inter-practice call coverage group of eight physicians.

Attending Staff Physician **August 2006 – June 2016**
Kent County Hospital, Warwick, RI
Part of Kent County Hospital clinical staff. Provided hospital on-call coverage. Participated in Grand Rounds for the Women's Health & OB/GYN Services Department. Treasurer of Department of OB/GYN and member of hospital-wide Quality Improvement Committee.

Attending Staff Physician **August 2006 – June 2016**
Women & Infants Hospital, Providence, RI
Part of Women & Infants Staff and Teaching Faculty. Provide hospital on-call coverage. Participated in Grand Rounds for the OB/GYN Services Department.

Clinical Instructor **August 2006 – June 2016**
Warren Alpert Medical School of Brown University, Providence, RI
As member of the community clinical faculty, participated in the education and training of OB/GYN residents and medical students in the clinical, hospital and surgical settings. Honored with several excellence in teaching awards, including Top Community-based Faculty Teacher of the Year Award.

AWARDS AND RECOGNITION

Chief Resident Community-Based Faculty Award 2012 - 2013
Warren Alpert Medical School of Brown University / Women & Infants Hospital, Providence, RI

Top Community-based Faculty Teacher of the Year Award 2010 - 2011
Warren Alpert Medical School of Brown University / Women & Infants Hospital, Providence, RI

Excellence in Teaching Award 2007, 2009, 2010
Warren Alpert Medical School of Brown University / Women & Infants Hospital, Providence, RI

APPOINTMENTS

Board Member 2015 - 2017
Temple Sinai, Atlanta, GA

Board Member 2015 - 2016
Planned Parenthood Southeast, Atlanta, GA

Co-Chair Sisterhood 2015 - 2016
Temple Sinai, Atlanta, GA

Quality Improvement Committee 2010 – 2013
Kent County Hospital, Warwick, RI

Treasurer 2009 – 2013
Department of OB/GYN, Kent County Hospital, Warwick, RI

CareLINK Physician Advisory Group 2005 – 2006
St. Francis Hospital and Medical Center, Hartford, CT

Histology Teaching Assistant 1998 – 1999
University of New England College of Osteopathic Medicine, Biddeford, ME

MEMBERSHIP

Georgia OBGYN Society, 2014 - Present
Georgia Osteopathic Medical Association, 2018 - Present
New England Obstetric and Gynecology Society, 2006 - Present
Fellow, American College of Obstetricians and Gynecologists, 2002 - Present
American Osteopathic Association, 1996 – Present
Rhode Island Society of Osteopathic Physicians & Surgeons, 2006 - 2016

PRINT NAME: Janet B. Lefkowitz, DO DATE: 08 / 01 / 19

LAPSED LICENSE APPLICATION SUPPLEMENT

PRINT NAME: Janet B. Lefkowitz, DO DATE: 08 / 01 / 19

IMPORTANT NOTES

For purposes of the following questions, the time period is from the time you signed your last Massachusetts license application to the present.

If you answer "yes" to any of these questions, you must provide the additional information on pages 5-9.

QUESTIONS		YES	NO
1.	Have you been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
2.	Have you surrendered a license to practice medicine or any professional license or has your license or certificate been revoked? (You do not need to report a lapsed license.)		
3.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification been suspended or revoked?		
4.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
5-A.	Have you relinquished any medical staff membership or association with a health care facility?		
5-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility 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, administration or governing board?		
5-C.	Have you withdrawn an application for hospital privileges or appointment, or have you been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
6.	Have you been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		

		YES	NO
7.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
8.	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
9.	Have you had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
10-A.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
10-B.	Has any lawsuit, other than a medical malpractice suit, been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Janet B. Lefkowitz, DO DATE: 08 / 01 / 19

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 11 to 13. 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 impact one's functioning as a physician.

		YES	NO
11.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
12.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
13.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-13 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Janet B. Lefkowitz, DO DATE: 08 / 01 / 19

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that 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 certification does not imply that you will participate in the Medicare program).
- 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.

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

SIGNATURE: _____ DATE: 8 / 1 / 19