Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200
www.mass.gov/massmedboard

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

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Governor

KARYN E. POLITO
Lieutenant Governor

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Physician Member

GEORGE ZACHOS, ESQ.
Executive Director

January 21, 2020

VIA EMAIL

Re: PRR 2020.1.18 Dr. Misha Pangasa, BRN 276717

Dear

The Massachusetts Board of Registration in Medicine (the "Board") hereby responds to the above-referenced public records request, received on January 18, 2020 (the "request"), wherein you requested:

> all the documents in the file pertaining to Misha Pangasa, M.D., License Number 276717

Enclosed are 35 pages of records responsive to your request. Please be advised that certain portions of the records have been redacted and/or some records withheld from production due to an exemption pursuant to G.L. c. 4, § 7(26), as specified below:

- Personal information, including but not limited to social security numbers, drug provider identification numbers, home addresses, personal telephone numbers, personal email addresses, and dates of birth (*see* G.L. c. 4, § 7(26)(a) and (c); *see also* G.L. c. 66A, § 2; *see also* G.L. c. 93H; *see also* Board Policy 98-02); and

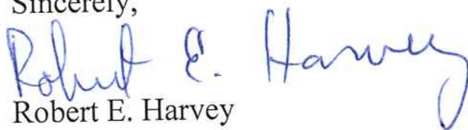
- Records obtained by and/or retained in the Board's Data Repository, including answers to certain questions appearing on application and/or renewal forms and any records of statutorily-mandated reports (*see* G.L. c. 4, § 7(26)(a); *see also* G.L. c. 112, § 5, and 243 1.03(14), CMR 2.13(2) through (4), and 2.14(2); *see also* Determinations of the Supervisor of Public Records, Docket Nos. SPR88/406, SPR89/275, and SPR18/1039);

The Board reserves the right to retrieve any exempted, privileged, or otherwise protected materials inadvertently included in this production. Any such production is not, and shall not be considered or deemed, a waiver of any applicable privileges or protections from disclosure.

The Board now considers this request closed.

If you believe the agency has violated G.L. c. 66, § 10, pursuant to G.L. c. 66, § 10A, and 950 CMR 32.08(1), you may submit an appeal to the Supervisor of Public Records in the Office of the Secretary of the Commonwealth or seek judicial review by commencing a civil action in Suffolk Superior Court.

Sincerely,



Robert E. Harvey
Board Counsel

Enclosure

RECEIVED

MAY 16 2018

Board of Registration in Medicine

276717

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

FULL LICENSE APPLICATION

Non-refundable Application Fee: $600.00 check or money order payable to the Commonwealth of Massachusetts.

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

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

Are you submitting primary source documents (medical education, previous postgraduate training, etc.) for licensure through FCVS? ☐ Yes ☒ No

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

PANGASA — MISHA

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

☒ M.D. ☐ D.O. ☐ PhD ☐ 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.)

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

NPI (National Provider Identifier) Number: 1255734364

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

*Mailing Address: ____ Number and Street Telephone: ____

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

Home Address: ____ Number and Street Telephone: ____

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

MP 7/31/18

Date R[illegible] 5 [illegible] 16 [illegible] 12

430

6[illegible]

Business Address: 300 Halket St Telephone: 9285029300
Number and Street

Pittsburgh PA 15213
City State/Province/Territory Zip (or postal) Code

Email Address: Fax number:

*** The Board will use your Email and/or Mailing Address for all correspondence**

Pre-medical School

		From	To
Name: University of Arizona	Degree: B.S.	Year: 2006	Year: 2010
Street: 1401 E. University Blvd	City: Tucson		State: AZ
Name:	Degree:	Year:	Year:
Street:	City:		State:

Medical School

Name: Weill Cornell Medical College		Degree: M.D.
Street: 1300 York Ave Rm C-118	City: New York	State: NY
Name:		Degree:
Street:	City:	State:

Medical School Graduation Date: 05 (Month) 2014 (Year)

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. 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, MCCQE, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)	
USMLE Step I	1	☒ P	☐ F
USMLE Step II	1	☒ P	☐ F
USMLE Step III	1	☒ 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 I		☐ P	☐ F
NBOME Part II		☐ P	☐ F
NBOME Part III		☐ P	☐ F
COMLEX Level 1		☐ P	☐ F
COMLEX Level 2		☐ P	☐ F
COMLEX Level 3		☐ P	☐ F
COMVEX		☐ P	☐ F
MCCQE – Part I		☐ P	☐ F
MCCQE – Part II		☐ P	☐ F
State Board Exam	(State of examination and year)	☐ P	☐ F

Timeline of Activities since Graduation from Medical School

Please provide a chronological listing by month and year of all activities since graduation from medical school. This would include all postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, military assignments, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. You must account for any time gaps of 30 days or more since your graduation from medical school. Failure to complete this section or address any time gaps may result in delay of licensure. Attach a separate sheet of paper if necessary. Do not write, "See CV" or "See attached"; you must complete this section AND attach your curriculum vitae. If none, enter "N/A".

Start Date (mm/yyyy)	End Date (mm/yyyy)	Institution/Place of Employment	Address (City, State/Country)	Position Held (Resident, Attending, Research Fellow, etc.)
07/2014	06/2015	Metropolitan Hospital Center New York Medical College	1901 1st Ave New York, NY 10029	Resident (intern)
~~07~~ 06/2015 (7/31/18)	06/2018	Magee Womens Hospital University of Pittsburgh	300 Halket St Pittsburgh, PA 15213	Resident
06/2014 (8/6/18)	07/2014			Vacation + residency orientation
/	/			
/	/			
/	/			
/	/			
/	/			
/	/			

Start Date (mm/yyyy)	End Date (mm/yyyy)	Institution/Place of Employment	Address (City, State/Country)	Position Held (Resident, Attending, Research Fellow, etc.)
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			
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__/__	__/__			
__/__	__/__			
__/__	__/__			

Questions 1 through 7 below must be answered by every applicant.

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

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): ____________________

4. List the medical specialt(ies) that you currently practice (if completing a postgraduate training program, list that specialty here): Obstetrics and Gynecology

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? (Your license will not be processed until you complete the required training – see instructions.) ☒ Yes ☐ No

7. Have you applied to enroll in MassHealth as a nonbilling or billing provider? (See Instructions) ☒ Yes ☐ No

8. Reason for requesting a Massachusetts medical license: New attending physician position

9. Name of Facility: Massachusetts General Hospital
   Address: 55 Fruit Street City: Boston

10. Anticipated starting date in Massachusetts: 09 04 2018

11. A current Curriculum vitae (CV) must be enclosed with your application. Please review to ensure this is an up-to-date CV.

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.

[signature]
Signature of Applicant

04 26 18
Month Day Year

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, Misha Pangasa
(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.

Misha Pangasa
Applicant's Signature

4/23/18
Date of Signature

Pangasa Misha
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

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: [signature] DATE: 4/23/18

PRINT NAME: Misha Pangasa DATE: 04 / 23 / 18

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide a detailed explanation and arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the underlying occurrence or action. Documents should be sent directly to you in a sealed envelope.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
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 been placed on probation or remediation by a medical school, graduate 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 or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: Misha Pangasa DATE: 04 / 23 / 18

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever 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?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever 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?		
10.	Have you ever 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.)		
11.	Has your privilege to manufacture, distribute, administer, 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 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 had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		—
14-A.	Has any medical malpractice claim ever 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?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever 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: MUSHA PANGASA DATE: 04 / 23 / 18

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. 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
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever 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 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Misha Pangasa DATE: 04 / 23 / 18

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.
- By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.
- 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, accurate and complete, to the best of my knowledge.

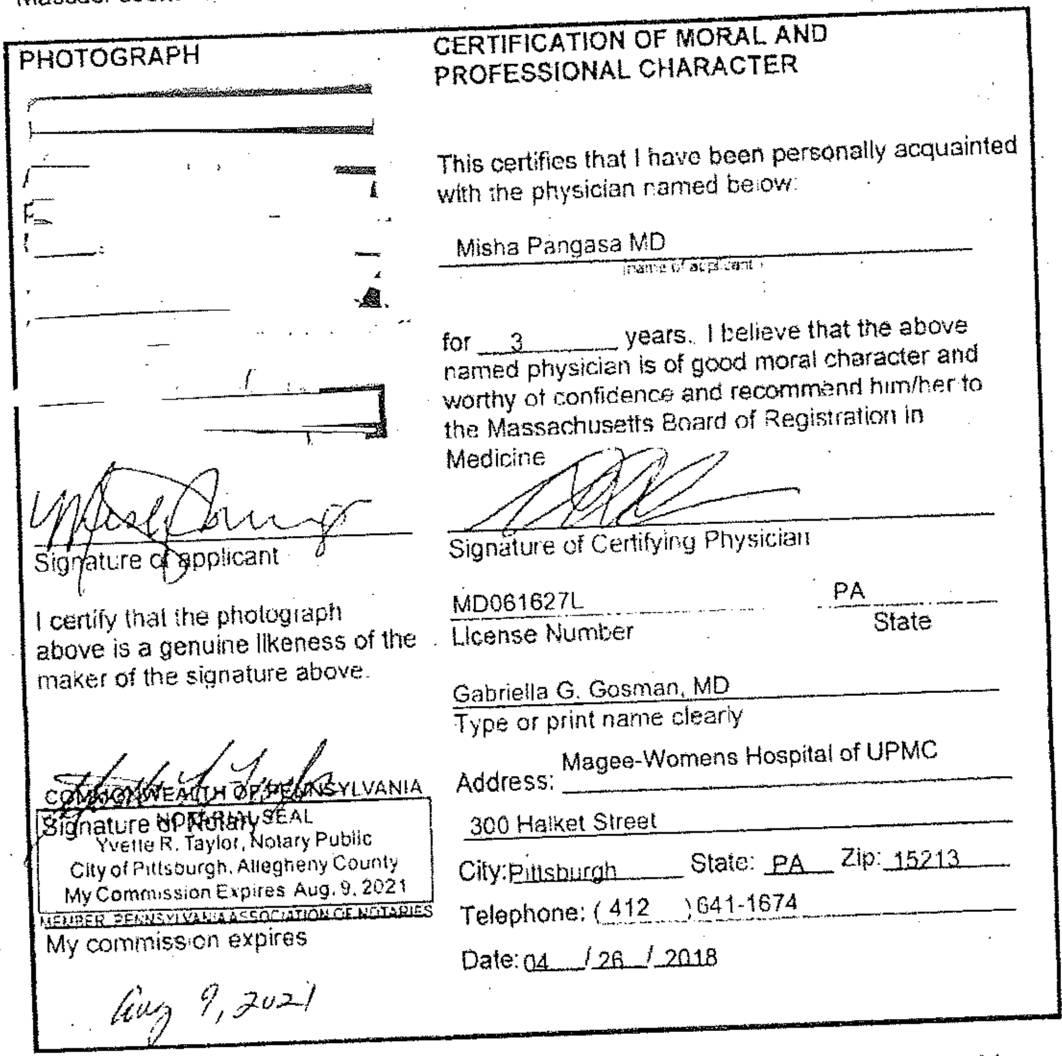
Applicant's Signature: Misha Pangasa Date: 4 / 23 / 18

SS

Commonwealth of Massachusetts
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 at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**



PHOTOGRAPH

Signature of applicant

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

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Yvette R. Taylor, Notary Public
City of Pittsburgh, Allegheny County
My Commission Expires Aug. 9, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Signature of Notary

My commission expires

Aug 9, 2021

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Misha Pangasa MD
(name of applicant)

for 3 years. I believe that the above named physician is of good moral character and recommend him/her to worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine

Signature of Certifying Physician

MD061627L — License Number

PA — State

Gabriella G. Gosman, MD
Type or print name clearly

Address: Magee-Womens Hospital of UPMC
300 Halket Street

City: Pittsburgh State: PA Zip: 15213

Telephone: (412) 641-1674

Date: 04 / 26 / 2018

5.17.18
SS

Instructions to the certifying physician:* Please answer every question, date this form, and return it to the applicant *in a sealed envelope with your signature across the seal.

Sealed Envelope

Initials SS

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

MEDICAL EDUCATION VERIFICATION – FORM A

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. Please note: **Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

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

Applicant's Signature: Misha Pangasa Date of Birth:

Name (Please type or print): Pangasa (Last Name) Misha (First Name) (Middle Initial)

Other Name(s) (Please type or print):

Name of Medical School: Weill Cornell Medical College

Address: 1300 York Ave City: New York State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Arizona

Undergraduate School Address: 1401 E. University Blvd. Tucson, AZ

Enrollment and Participation:

Our records indicate that Pangasa, Misha
(Print the applicant's name) (Last name) (First name) (Middle Initial)

attended our medical school for a total of 165 weeks (must be included) of continuous medical education on the following dates from 8/30/10 to 5/29/14
month/day/year month/day/year

This applicant:

Check one ☑ **was awarded the degree of** Doctor of Medicine on 5/29/14
month/day/year

☐ **will be awarded the degree of** ______ on __/__/__
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded a degree because** ______

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	Was the medical school training more than four (4) years for U S graduates or 6 years for international medical graduates or did the applicant take any leaves of absence (i.e. for research, public service participation in an M.D./Ph.D program) or for any "personal reasons"?		
2	Was the applicant ever placed on probation or remediation?		
3	Was the applicant ever disciplined or under investigation?		
4	Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation for any of the above questions ______

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 [signature]

Print Name Shira Markert

Title Assistant Registrar

Date 5/8/18 Telephone (212) 746 1050

E-mail address registrar@med.cornell.edu

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Seal Verified

DATE: 7/25/18

INITIALS: TJZ

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649

www.dos.pa.gov

04/24/2018

Verification/Certification of License

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	MISHA PANGASA
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD458885
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	07/27/2016
LICENSE EXPIRATION DATE:	12/31/2018
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

Ian J. Harlow, Commissioner
Bureau of Professional and Occupational Affairs

Sealed Envelope

Initials SS

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

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: Misha Pangasa Date: 4/24/18

Print or Type Name: Misha Pangasa

Name and Address of Institution: Metropolitan Hospital Center
1901 1st Avenue
New York, NY 10029

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal

Name of Institution: New York Medical College at Metropolitan Hospital and Westchester Medical Center

Name of Institution, if different when applicant attended:

Verification for: Misha Pangasa, MD
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately)	PGY (1 2 3 4 etc)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
Resident	1	OB-GYN	7/1/14	6/30/15	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: Misha Pangasa

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **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 postgraduate 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?		

COMMENTS: ______________________________

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct

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: Sari J Kaminsky MD

Print Name: SARI J. KAMINSKY, MD

Academic Title: Program Director, Professor of Cl. Ob-Gyn

Telephone: (212) 423-6796 Today's Date: 4/26/2018

E-mail address: sari.kaminsky@nyc.hhc.org

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

5.17.18
SS

Seal Missing
Date 5.17.18
Initials SS

RECEIVED AUG 02 2018 Board of Registration in Medicine

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

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: Misha Pangasa Date 4-23-18

Print or Type Name: Misha Pangasa

Name and Address of Institution: Magee Womens Hospital of UPMC
300 Halket St
Pittsburgh, PA 15213

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal

Name of Institution: UPMC MEDICAL EDUCATION

Name of Institution, if different when applicant attended: ______

Verification for: MISHA PANGASA MD
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by ACGME, AOA, RSC, or not accredited)
RESIDENCY	2	OB/GYN	06 20 15	06 19 16	Yes	ACGME
RESIDENCY	3	OB/GYN	06 20 16	06 19 17	Yes	ACGME
~~RESIDENCY~~	~~4~~	~~OB/GYN~~	~~06 20 17~~	~~06 19 18~~	~~In progress~~	~~ACGME~~
Residency	4	Ob/Gyn	06 20 17	06 19 18	Yes	ACGME

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

GGG 7/24/18

RECEIVED
AUG 20 2018
Board of Registration in Medicine

APPLICANT'S NAME: Misha Pangasa MD

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **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 postgraduate 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?		

COMMENTS. ______________________

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct

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 [signature]

Print Name Gabriella G. Gosman MD

Academic Title Professor & Program Director

Telephone 412 641-1674 Today's Date ~~07/24/18~~ 07/24/2018

E-mail address ggosman@mail.magee.edu

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

Seal Verified

DATE: 8/6/18

INITIALS: [initials]

Envelope
SS

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AUG 2 0 2018
Board of Registration in Medicine

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

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:

- *This form must be completed by a supervising physician who can evaluate your clinical performance*
- *At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms*
- *Evaluation forms must be current within 120 days prior to Board review*
- *The Evaluator must have no financial interest in your licensure in the State of Massachusetts.*

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice

Signature of applicant: Misha Pangasa Date 4 / 23 / 18

Please PRINT your name Misha Pangasa

Name of Evaluating Hospital/Workplace Magee Womens Hospital of UPMC State PA

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal
- The Board may provide a copy of this Form and any attachments to the applicant

1. **Date(s) of applicant's affiliation at facility (month/year)?** From 06 / 2015 To: 06 / 2018

2. **In what capacity did you supervise the applicant?** ☐ Department Chair ☐ Chief of Service ☐ Medical Director ☒ Training Director ☐ Supervising Physician ☐ Chief Medical Officer

3. **Applicant's Status:** ☐ Intern ☒ Resident ☐ Fellow ☐ Staff Member ☐ Other ______

4. **Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts?** ☐ YES ☒ NO

5. **Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).**

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge	✓				
Clinical competency	✓				
Professional judgment	✓				
Character and ethics	✓				
Technical skills	✓				
Relationships with staff	✓				
Relationship with patients	✓				
Cooperativeness/ability to work with others	✓				

(Continued on page 2)

GLG
7/24/18

6. **Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?** ☐ YES ☒ NO (if "yes" please explain below)

7. **Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.** ☐ YES ☒ NO

8. **Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.**

9. **The above comments are based on the following:**

☒ Personal observation ☐ General impression ☒ A composite of evaluations by other physicians

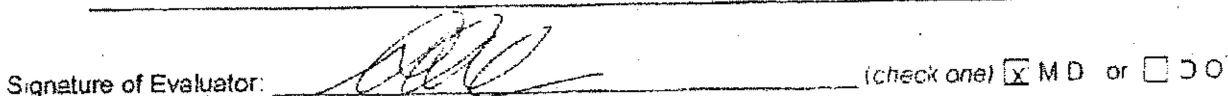
☐ Other______________________

10. Recommendations:

☒ Recommend for licensure in Massachusetts.

☐ Recommend for licensure in Massachusetts, with the following reservations:

☐ Do not recommend for the following reason(s):



Signature of Evaluator: ______________________ (check one) ☒ M D or ☐ D O

Name of Evaluator (Printed) Gabriella G. Gosman, MD Date ~~04 / 26 /2018~~ 07/24/2018

Title/Position: Residency Program Director, Obstetrics & Gynecology

E-mail address: ggosman@mail.magee.edu Phone number 412-641-1874

PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

MISHA PANGASA. M.D.

EDUCATION AND TRAINING

	Postgraduate
6/2015 – 6/2018	University of Pittsburgh Medical Center, Pittsburgh, PA Magee Womens Hospital, Obstetrics and Gynecology Residency
7/2014 – 6/2015	New York Medical College, New York, NY Metropolitan Hospital, Obstetrics and Gynecology Internship
	Graduate
8/2010 – 5/2014	Weill Cornell Medical College, New York, NY Doctor of Medicine, May 2014
	Undergraduate
8/2006 – 5/2010	University of Arizona, Tucson, AZ Bachelor of Science, May 2010, *Summa Cum Laude* Major: Molecular and Cellular Biology, Minor: Political Science

CERTIFICATION AND LICENSURE

2016 – present	Commonwealth of Pennsylvania Bureau of Professional and Occupational Affairs Medical Physician and Surgeon
2016 – present	Drug Enforcement Administration Registration
2016	Fundamentals of Laparoscopic Surgery

MEMBERSHIP IN PROFESSIONAL SOCIETIES

2014 – present	American Medical Women's Association
2013 – present	American College of Obstetrics and Gynecology

APPOINTMENTS AND POSITIONS

6/2013 – 6/2014	Canopy Innovations, Inc., *Medical Consultant* New York, NY *Created medical content for healthcare startup company*
6/2009 – 6/2010	Teach For America, *Campus Campaign Coordinator* Tucson, AZ *Maintained organization's high-profile presence on campus through presentations and on campus marketing*

PUBLICATIONS

1. Lekovich JP, Amrane S, **Pangasa M**, Pereira N, Frey MK, Varrey A, Holcomb K. Comparison of Human Papillomavirus Infection and Cervical Cytology in Women Using Copper and Levonorgestrel-Containing Intrauterine Devices. Obstetrics and Gynecology. 2015;125(5):1101-1105

2. Spratt DE, Zumsteg Z, Ghadjar P, **Pangasa M**, Pei X, Fine SW, Yamada Y, Kollmeier M, Zelefsky MJ. *Prognostic Importance of Gleason 7 Disease Among Patients Treated With External Beam Radiation Therapy for Prostate Cancer: Results of a Detailed Biopsy Core Analysis.* Int J Radiat Oncol Biol Phys. 2012 Nov 20. pii: S0360-3016(12)03663-2

POSTER/ABSTRACT PRESENTATIONS

1. **Pangasa M,** Kennedy J, Himes K, Facco F. *Flu vaccine and pregnancy – missed opportunities in the postpartum period.* Presented at the Society for Reproductive Investigation Annual Meeting, San Diego, CA in March 2018.

2. Suidan RS, Ramirez PT, Zivanovic O, Long KC, Zhou Q, **Pangasa M**, Levenback CF, Gardner GJ, Sonoda Y, Chi DS. A multicenter assessment of surgical findings associated with gross residual disease at primary debulking surgery for advanced epithelial ovarian cancer. Presented at the Annual Meeting on Women's Cancer, San Diego, CA, March 2016.

3. Lekovic J, **Pangasa M**, Chan M, Reiss J, Prasad L, Taubel D. *Does hysterectomy improve patients' understanding of the anatomy and physiology of the female reproductive organs? A survey.* Presented at the American Society for Reproductive Medicine Annual Meeting, Boston, MA. October, 2013.

4. Lekovic J, Movilla P, Varrey A, **Pangasa M**, Prasad L, Taubel D. *Poor understanding of female reproductive tract anatomy, physiology and its effect on perception – A survey.* Presented at the American Society for Reproductive Medicine Annual Meeting, Boston, MA. October 2013.

5. **M. Pangasa**, N.S. Ivascu, S. Paul, P.C. Lee, J.L. Port, N.K. Altorki, L.N. Girardi, O. Isom, B.M. Stiles. *Tracheostomy in critically ill cardiac surgical patients: safety and 30-day outcomes when performed by a dedicated cardiothoracic critical care team.* Presented at the American Association for Thoracic Surgery Annual Meeting, San Francisco, CA. April, 2012

6. Jessica S. Fortin, **Misha Pangasa**, Yong Qin, Robert V. Brown, Samantha Kendrick, Vanessa C. Gaerig, Tracy A. Brooks, Laurence H. Hurley. Univ. of Arizona, Tucson, AZ. *Evaluation of G-quadruplex structures that stabilize the human PDGFR- 2 promoter region as therapeutic targets for pancreatic cancer.* In: Proceedings of the 100th Annual Meeting of the American Association for Cancer Research; 2009 Apr 18-22; Denver, CO. Philadelphia (PA): AACR; 2009

PROFESSIONAL ACTIVITIES AND SERVICE

2017 – 2018	Performance in *The Vagina Monologues* through Magee Resident Life Committee in support of Pittsburgh Action Against Rape
2017 – present	Magee Resident Wellness Committee
2016 – present	Magee Resident/Fellow Patient Safety Leadership Committee
2016 – present	Graduate Medical Education, Patient Safety and Quality Improvement Committee, UPMC
2012 – 2014	Weill Cornell Community Clinic, Women's Health Division, Student Clinician
2011 – 2014	Medical Students for Choice, President of Weill Cornell Medical College chapter
2013 – 2014	Longitudinal Education Experience & Advancing Patient Partnerships (LEAP) Pregnancy Partners, Education Coordinator
2008 – 2010	BioLink Science Outreach Fellow for STEM outreach to K-12 female students
2009 – 2010	Women of Biosciences Toastmasters Association, President

HONORS & AWARDS

2018 **Ryan Residency Family Planning Award**

2014 **The George Ladas Prize for Efficiency in Gynecology** – awarded to senior medical student who has demonstrated greatest proficiency in gynecology

2013 **Dr. Robert C. Knapp Medical Student Award from Hearing Ovarian Cancer Whisper Foundation** - $3K awarded to 16 medical students nationally for exploration into the field of gynecologic oncology

2011 **American Association for Thoracic Surgery Summer Intern Scholarship** - $2.5K awarded to 35 medical students nationally for summer exploration in cardiothoracic surgery

2009 **Phi Beta Kappa Howard Award** – awarded to a Phi Beta Kappa student with 4.0 GPA with demonstrated commitment to community service

EDUCATIONAL PRESENTATIONS

2017 **Patients, Policy, and Physician Advocacy: What Every OB/GYN Should Know About Health Care Policy**, Grand Rounds, Department of Obstetrics, Gynecology, and Reproductive Sciences, Magee Womens Hospital, Pittsburgh, PA

2017 **Sexuality, Family Planning, and the Media**, Division of Family Planning, Magee Womens Hospital, Pittsburgh, PA

2016 **Endometrial Polyps: Diagnosis and Management**, Gynecology Conference, Division of Gynecologic Specialties, Magee Womens Hospital, Pittsburgh, PA

2016 **Abnormal Placentation**, Perinatal Assessment Conference, Division of Maternal Fetal Medicine, Magee Womens Hospital, Pittsburgh, PA

2016 **Absence of Cavum Septi Pellucidi on Ultrasound**, Genetics Conference, Division of Genetics, Magee Womens Hospital, Pittsburgh, PA

2015 **Overview of Sterilization**, Gynecology Conference, Division of Gynecologic Specialties, Magee Womens Hospital, Pittsburgh, PA

2015 **Obesity in Pregnancy**, Grand Rounds, Department of Obstetrics and Gynecology, Metropolitan Hospital Center, New York, NY

2014 **Evaluation of Amenorrhea, Gynecology Conference, Department of Obstetrics and Gynecology, Metropolitan Hospital Center, New York, NY**

Please be aware that there is a one month gap of vacation between medical school graduation 5/2014 and start of residency 7/2014.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Misha Pangasa, M.D. **License No.:** 276717

Current Status: Active **License Expiration Date:** 5/16/2019

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
55 Fruit Street
Founders 4
Boston
Massachusetts - 02114
United States of America
(928) 502-9300

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
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

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
Massachusetts General Hospital	

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Misha Pangasa, M.D. **License No.:** 276717

11) Care of patients in Massachusetts
Average weekly hours involved in:
a) inpatient care 16 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2019	12/31/2019	Claims made with tail coverage

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

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?

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 or physical condition that currently impairs your ability to practice medicine?

24) Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?

25) **MassHealth Enrollment Status**
I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

26) **Domestic Violence and Sexual Violence Training Requirement**
Have you completed training and education on the issue of domestic violence and sexual violence? Yes

Physician Name: Misha Pangasa, M.D. **License No.:** 276717

Office Based Surgery

Please indicate your office Facility Classification under the MMS office Based Surgery Guidelines

You indicated that you are a Level II office

Provide a brief description of the types of surgery performed in your office.

D&C, hysteroscopies done under light sedation.

Are you in compliance with all requirements of the MMS as defined by the MMS Office Based Surgery guidelines and endorsed by the Board of Registration in Medicine? Yes

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Misha Pangasa, M.D. **License No.:** 276717

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.

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

[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.**