REDACTED COPY

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: $350.00 TO BE SUBMITTED

Filed: 330
By: PE
Form of Fee: 350.

For Office Use

Application # _____

Certificate # 79380 Date of Issue 3/4/94

Please Print

SWORN STATEMENT

Date: March 24, 1994

Name STEVEN (First) JOSEPH (Middle) RALSTON (Last)

Address [redacted]

Date of Birth [redacted]

Place of Birth Passaic, New Jersey

Name on Birth Certificate Same

Phone # (203) 4978861

Pre-Medical Education

School Yale College

Years Attended 1981-1985

Medical Education

School Columbia College

Years Attended 1986-1990

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Columbia College	Medical School	8/86 - 5/90
Yale-New Haven Hospital	Resident Staff	6/90 - 6/94

Is this your first full license? NO If applicable, please list all other states where you are or have been licensed: Pennsylvania

Other names under which you have been licensed: None

List Specialty Boards by which you are certified: None

RECEIVED
MAR 28 1994
BOARD OF REGISTRATION IN MEDICINE

REASON APPLYING FOR A MA LICENSE Employment

Anticipated starting date if you have position pending in Massachusetts: 7/1/94

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

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

Steven Ralston

Date: 3/24/94

SIGNATURE OF APPLICANT

EN

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR MD LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: STEVEN J RALSTON Day time phone #: _____

MAILING ADDRESS: _____ Business Address: _____

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution *denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)*?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
12. Have you ever, for any reason, lost American Specialty Board Certification?		
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, *restricted or surrendered, or have you been called before or warned by this state or any other* jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.
I 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 hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: _____ DATE: 3/24/94

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

Registration No.	Status	Fee	Renewal Date	Late Fee
79380	ACTIVE	$250.00	05/13/95	$25.00

Mailing Address:
STEVEN JOSEPH RALSTON, M.D.

Correction of Mailing Address

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

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

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

For Office Use Only
M.R. _____
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BOARD OF REGISTRATION IN MEDICINE

Pre-Printed Information

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

2. Business Address:

3. Date of Birth: Sex: M
Lic. Issue Date: 05/04/94 SS#:

Home Phone: (203)497-8861 Business Phone: ( ) -

4. Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
Year Graduated: 90 Degree: MD

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

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

Code	Hours per Week in Mass.
OBG	60 hrs/wk

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

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

Corrections of Pre-Printed Information

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

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

Home: _____ Business: 617 581 3900

Full Name of Medical School: _____

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

Code	Hours per Week in Mass.

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: RALSTON Registration Number: 79380

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: __ __ 7 / __ (AP) Facility Code: __ __ __ / __ (AP) Facility Code: __ __ __ / __ (AP)

Facility Code: __ __ __ / __ (AP) Facility Code: __ __ __ / __ (AP) Facility Code: __ __ __ / __ (AP)

If 999, print name(s): _____

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

Facility Code: __ __ __ Facility Code: __ __ __ Facility Code: __ __ __ Facility Code: __ __ __ Facility Code: __ __ __

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit __ If applicable, check one.
List Insurer: Mass Medical Professional Insurance Assoc.

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

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

13. a) What is your principal work setting? (See Table 4) 2 5

b) Care of patients in Massachusetts (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 20 hrs/wk
ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 20 hrs/wk

c) *Approximately what percentage of your patient care hours are in primary care?* (See instructions for definition of primary care.) 50 %

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

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

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

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

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: 3/27/95

Commonwealth of Massachusetts Board of Registration in Medicine

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

Physician Registration Renewal Application

5/5

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
  - **Return renewal application in GREEN envelope.**
  - **Enclose check with coupon in BLUE envelope.**

Registration No.: 79380 Renewal Date: 05/13/97

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

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

3. A) Mailing/Home Address:

STEVEN JOSEPH RALSTON, M.D.

B) Business Address:

Home Phone:
Business Phone: (617)581-3900

4. A) Date of Birth: , , C) Sex: M
B) Lic. Issue Date: 05/04/94 D) SS#:

5. A) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
B) Year Graduated: 90 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	60	Obstetrics and Gynecology

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

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

9. A) Other states where you are now licensed to practice
Abbr: PA
B) States where you previously were licensed to practice
Abbr: PA

Corrections (type or print)

Other Name(s):

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

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

Home: ( )
Business: (617) 636 4625
Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code(s)	Hours Per Week in Mass.
M F M	60

If OS, Print Specialty:

Code: OBG Code:

Federal (DEA):
Mass:

Abbr: Abbr:

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

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PRINT NAME AND NUMBER: Last Name: RALSTON Registration Number: 79380

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).

Facility Code: 007/X(AP) Facility Code: 108/X(AP) Facility Code: ___/__(AP)
Facility Code: 299/X(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)
If 999, print name(s): _____

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

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

11. My medical malpractice insurance is covered by a) X Insurance Carrier ____b) Letter of Credit
Name of Insurer: MEMC Insurance Company of Vermont.

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

I am (check one) a)____ Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption:_____

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

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

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

1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 30 hrs/wk

2) *What is the approximate percentage of your patient care hours in primary care ?* 10 %

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)?		

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

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

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

Signature _____ Date: 4/10/97

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

Registration No.: 79380 Renewal Date: 05/13/1999 1. Current Status: Active

RECEIVED MD Board of Registration in Medicine 5 [redacted]

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

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

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

3. A) Mailing/Home Address:
STEVEN JOSEPH RALSTON, M.D.

B) Business Address:

Home Phone:
Business Phone: (617) 636-4625

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

5. A) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
B) Year Graduated: 1990 C) Degree: MD

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass.
MFM 60 Maternal and Fetal Medici

Please make corrections (type or print)

Other Name(s): _____

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

Other Address: 750 Washington St #360
City/Town: Boston State: MA
Zip: 02111 Country: _____

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

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

Full Name of Medical School:

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

Code(s)	Hours Per Week in Massachusetts

If OS, Print Specialty: _____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr: ~~PA~~
B) States where you previously were licensed to practice
Abbr: PA

Abbr: _____
Abbr: P A

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

♻

PRINT NAME AND NUMBER: Last Name: Ralston Registration Number: 79380

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

Facility Code: 532/ ✓ (AP) 5 % Facility Code: 107/ ✓ (AP) 5 % Facility Code: 99/ (AP) 15 %

Facility Code: 299/ ✓ (AP) 75 % Facility Code: 40/ ✓ (AP) 2 % Facility Code: / (AP) %

If 999, print name(s): _____

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

Name of Insurer: RI Sound Enterprises Insurance Co. Ltd. "RISE" Alternatively, *indicate as follows:*

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 20 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

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

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

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 3/3/99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.: 79380 Renewal Date: 05/13/2001

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

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

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

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3. A) Mailing/Business Address:
STEVEN JOSEPH RALSTON

B) Home Address:

Home Phone:

Business Phone: (617)338-6360

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: 750 Washington St, Box #360
City/Town: BOSTON State: MA
Zip: 02118 Country: _____

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (617) 636 3200

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

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: b) Sex: M

c) SS#:

5. a) Name of Medical School:

Columbia Univ. College of Physicians & Surgeons

b) Year Graduated: 1990 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
MFM	0	Maternal and Fetal Medicine
	0	

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: 06 Code: 0603

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

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

b) States where you were previously licensed (Abbr.)
___ ___ ___ ___ ___ ___ ___ ___
PA

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

Facility Code: 299 / ✓ (AP) 75 % Facility Code: 99 / ✓ (AP) 10 % Facility Code: 532 / ✓ (AP) 1 %
Facility Code: 107 / ✓ (AP) 10 % Facility Code: 40 / ✓ (AP) 4 % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: RALSTON LICENSE NUMBER: 79380

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

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

13. A. What is your principal work setting? (See Table 4) 1 0

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

1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 25 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 20 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 3/1/01

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

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

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

Physician Registration Renewal Application

RECEIVED
MAR 18 2003
Board of Registration in Medicine

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

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

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 79380 Renewal Date: 05/13/2003

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

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

2. Other Name(s) [redacted], under which you were licensed:

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

A) Mailing/Business Address:

3. STEVEN JOSEPH RALSTON
NEW ENGLAND MEDICAL
750 WASHINGTON ST. #360
BOSTON, MA 02111

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

B) Home Address:

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

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

Home Phone:

Business Phone: (617)636-3200

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

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

5. a) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
b) Year Graduated: 1990 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
MFM	60	Maternal and Fetal Medicine

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code: OG03

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

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

b) States where you were previously licensed (Abbr.)
PA

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

Facility Code: 299 / ✓ (AP) 85 % Facility Code: 58 / ✓ (AP) ____ % Facility Code: 40 / ✓ (AP) ____ %
Facility Code: 99 / ✓ (AP) 10 % Facility Code: 103 / ✓ (AP) ____ % Facility Code: 534 / ✓ (AP) 5 %
If 999, print name(s): _____

PRINT YOUR LAST NAME: RALSTON LICENSE NUMBER: 79380

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): New England Medical Ctr Indemnity Co Policy dates: From: 12/01/02 To: 10/01/03
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.
☐ Otherwise exempt Please explain exemption:

12. What is your principal work setting? (See Table 4) 10 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: A) inpatient care 60 hrs/wk B) outpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. CLAIMS MADE (New or Pending): Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. CLAIMS (Resolved): Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.
CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).
See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: Date: 3/13/03

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

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

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston **License No.: 79380**

PART A

1) Current Status: Active **Renewal Due Date:** 04/15/2005 **Birth Date**

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

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

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

2a) MAILING ADDRESS

New England Medical Center
750 Washington Street, Box 360
Boston, MA 02111

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

New England Medical Center
750 Washington Street, Box 360
Boston, MA 02111

Phone: (617)636-3200

☐ *Check here to change this address*

BOARD OF REGISTRATION IN MEDICINE
2005 MAR -7 PM 1:29
RECEIVED

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Maternal and Fetal Medicine	☐	
	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston **License No.: 79380**

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

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

Principal Work Setting: Hospital Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 40

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

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Cambridge Public Hlth Commission (The)	☐	Admitting		rare
Lawrence General Hospital	☐	"		8
Lowell General Hospital	☐	"		rare
Melrose-Wakefield Hospital	☐	"		rare
Northeast Hospital Corporation	☐	"		4
South Shore Hospital	☐	"		rare
	☐			

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

Average weekly hours involved in: a) inpatient care 10 hrs/wk Change to: ____ hrs/wk

b) outpatient care 10 hrs/wk Change to: ____ hrs/wk

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

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

☒ **Insurance Carrier** *(complete below)*

Current Insurance Carrier: New England Medical Change to: _____

Policy dates: From 10/1/04 To 9/30/05 *(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston **License No.: 79380**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* ☐ Yes ☒ No
If Yes, please complete Form PCA-O "Office Based Surgery"

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

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

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston **License No.: 79380**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

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

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

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

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

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

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

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: _____ Date: 3/2/05

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston, M.D. **License No.: 79380**

03/22/07 $1 425

PART A

1) Current Status: Active **Renewal Due Date:** 04/15/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
New England Medical Center
750 Washington Street, Box 360
Boston, MA 02111

☐ *Check here to change this address*

2b) HOME ADDRESS RECEIVED

Phone:

☒ *Check here to change this address*

2c) BUSINESS ADDRESS
New England Medical Center
750 Washington Street, Box 360
Boston, MA 02111

Phone: (617)636-3200

☐ *Check here to change this address*

Please make corrections (print)

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

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

Correct your E-mail and Fax Number below:
sjralston@tufts-nemc.org
617 636-4202

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Maternal and Fetal Medicine	☐	
	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston, M.D. **License No.:** 79380

08/22/07 16:42:29

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		PA

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Cambridge Public Hlth Commission (The)	Cambridge	MA	☐
Lawrence General Hospital	Lawrence	MA	☐
Lowell General Hospital	Lowell	MA	☐
Melrose-Wakefield Hospital	Melrose	MA	☐
Northeast Hospital Corporation	Beverly	MA	☐
Planned Parenthood League of MA	Brighton	MA	

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

Average weekly hours involved in: a) inpatient care 10 hrs/wk Change to: _____ hrs/wk

b) outpatient care 10 hrs/wk Change to: _____ hrs/wk

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

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

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: New England Medical Change to: _____

Policy dates: From 10/1/06 To 9/30/07

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* ☐ Yes ☒ No

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston, M.D. **License No.: 79380**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Steven J Ralston, M.D. **License No.: 79380**

08/22/07 15:39

PART C

Check One:

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

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

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

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

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

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

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

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

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: _____ Date: 8/19/07

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

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☐ Mrs. ☐ Ms. ☐ Mr. Your First Name _____ Your Last Name _____ Patient Name (if different) _____

Street Address _____ Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Business/Daytime Phone _____ Home Phone _____

Complaint against M.D. _____, D.O. _____, Acupuncturist _____.
(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)
This complaint cannot be processed without the **full** name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist **(one name per form)** Photocopies are acceptable.

Steven Ralston

Address New England Medical Center
750 Washington St, B

City Boston State MA Zip Code 02111

Business Phone

Name and Location of Health Care Facility (if known)

Nature of Complaint

☐	Substandard Medical Care	☐	Drug Dealing
☐	Professional Misconduct	☐	Criminal Conviction
☐	Sexual Misconduct	☐	Patient Neglect/Abandonment
☐	Rude or Discourteous Behavior	☐	Unlawful Discrimination
☐	Impaired by Alcohol or Drugs	☐	Billing for Services Not Rendered
☐	Impaired by Mental or Emotional Illness	☐	Failure to Supervise Staff
☐	Failure to Provide Medical Records	☐	False Advertising
☐	Overcharge for Medical Records	☐	Fraud

☐ OTHER _____

N/A

Failure to **complete** and **sign** this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: _____
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

Signature of Patient: _____ Date: _____
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

_____

_____

_____

_____

_____

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☐ Yes, ☐ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☐ No

How long have you (or patient) been under this physician's care?
☐ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☐ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other_____

Are you (or patient) expected to pay a portion of this bill out of pocket?
☐ Yes, ☐ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☐ No

Is the fee or copayment in dispute?
☐ Yes, ☐ No

Has the physician been contacted about this complaint?
☐ Yes, ☐ No

Dates of Treatment: _____

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3008
CONNECTION TEL	16179729591
SUBADDRESS	
CONNECTION ID	CREDENTIALING
ST. TIME	08/29 13:33
USAGE T	01'49
PGS. SENT	14
RESULT	OK

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

August 29, 2005

Ingrid Arrecis
Tufts Health Plan
Fax: (617) 972-9591
Page 1 of 14

RE: Your request for information

Dear Ms. Arrecisl:

Enclosed please find one closed complaint regarding Dr. Steven J. Ralston. I trust this information is helpful.

Sincerely,

Sarah D. Hopkins

Sarah Donnelly Hopkins
Assistant General Counsel

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

June 7, 2005

Re: Steven Ralston, M.D.
Docket Number: 05-217

Dear

Enclosed please find a copy of Dr. Ralston's response. You will be notified when there is a disposition in this matter.

In the meantime if you have any questions, I can be reached at (617) 654-9800 ext. 4033.

Very truly yours,

Jennifer Brown

Jennifer A. Brown
Consumer Protection Coordinator

JAB/bmh
Enclosure