Commonwealth of Massachusetts

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: Medical Board of California

ADDRESS: 2005 Evergreen Street Suite 1200

CITY: Sacramento STATE: CA ZIP: 95815

(TYPE OR PRINT) PHYSICIAN'S NAME: Sarah Helene Averbach

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MASSACHUSETTS LICENSE NUMBER: 255250

SIGNATURE OF PHYSICIAN: _____

Signed under the penalties of perjury

DATE: 10/14/13

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

Date Received: 10/18/13
Check #: 677
Amount: $ 100.00
Init: CH

BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880

RETURN SERVICE REQUESTED

7011 3500 0002 1957 [illegible]

$ 06.41

MAILED FROM ZIPCODE 01

#255250

RECEIVED
JUL – 7 2014
BOARD OF REGISTRATION IN MEDICINE

Sarah H Averbach M.D.

RETURN TO SENDER

RETURN TO SENDER

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Commonwealth of Massachusetts

Board of Registration in Medicine

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

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

Board of Registration in Medicine – Licensing Division

April 17, 2013

Dear Doctor Averbach

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90 day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2012 and your license is issued on July 1, 2012, your renewal date will be September 1, 2013. However, if your birthday falls on September 1, 2012 and your full license is issued on January 1, 2012, you will be required to renew by your birthday of September 1, 2012. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below. Thank you.

Sincerely,

Marion Thornton

Licensing Analyst

Please select one of the boxes below:

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

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

My birth date is _____ gnature: _____

Application #: 255250

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

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

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

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

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

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

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☐ Male ☒ Female

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

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

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

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)

Business Address: 330 Brookline Ave, Kirstein 3 (Number and Street) Telephone: 617-667-2285

Boston	MA	02215
City	State/Province/Territory	Zip (or postal) Code

E-mail Address: _____ Fax number: 617-667-0842

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

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

Date Rec'd: 4.3.13

Check #: 602

Check Amount: $ 602.-

Initials: _____

Pre-medical School

			From	To
Facility: University of California San Diego	Degree: BS		09 /01 /99	06 /30 /03
Street: 9500 Gillman Drive	City: La Jolla	State: CA		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: University of San Francisco	Degree: MD		08 /27 /04	05 /15 /09
Street: 505 Parnassus Drive	City: San Francisco	State: CA		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 06 / 2009
Month Year

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

Postgraduate Education:

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

			From	To
Facility: Beth Israel Deaconess Medical Ctr.	Position: Resident		06 /12 /09	06 /14 /13
Street: 330 Brookline Ave	City: Boston	State: MA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

Examination History

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

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

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I	4/06	[X] P	[ ] F	1
USMLE Step II	CK 6/16/07 CS 2/09	[X] P	[ ] F	1
USMLE Step III	2/11	[X] P	[ ] F	1
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	
LMCC – Single		[ ] P	[ ] F	
LMCC – Part I		[ ] P	[ ] F	
LMCC – Part II		[ ] P	[ ] F	
State Board Exam	(State of examination)	[ ] P	[ ] F	

Hospital Affiliations and Employment

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

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

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

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): _____ Certification date: __/__/__
   _____ Certification date: __/__/__

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

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

6. Reason for requesting a Massachusetts medical license: I will be practicing OBGYN in the Harvard Faculty Medical Physicians Practice

7. Name of Facility: Bowdoin Street Health Center
   Address: 230 Bowdoin Street City: Dorchester, MA

8. Anticipated starting date in Massachusetts: 07 / 01 / 2013

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

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

_____ 04 / 2 / 2013
Signature of Applicant Month Day Year

(Continued on page 5)

Boston University School of Medicine
Continuing Medical Education

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

Sarah Averbach, MD
26 Wenham Street Apt 1
Jamaica Plain, MA 02130

Boston University School of Medicine

certifies that

Sarah H Averbach, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: Internet Module 1

and is awarded **1.00** *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 9th, 2013
Maximum Credits: 1

Score: 83

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

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

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

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

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

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

Sarah Averbach, MD
26 Wenham Street Apt 1
Jamaica Plain, MA 02130

Boston University School of Medicine

certifies that

Sarah H Averbach, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: Internet Module 2

and is awarded 1.00 *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 9th, 2013
Maximum Credits: 1

Score: 100

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

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

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

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

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

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

Sarah Averbach, MD
26 Wenham Street Apt 1
Jamaica Plain, MA 02130

Boston University School of Medicine

certifies that

Sarah H Averbach, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: Internet Module 3

and is awarded **1.00** *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 9th, 2013
Maximum Credits: 1

Score: 75

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

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

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

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

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

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

Sarah Averbach, MD
26 Wenham Street Apt 1
Jamaica Plain, MA 02130

Boston University School of Medicine

certifies that

Sarah H Averbach, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: Internet Module 4

and is awarded 1.00 *AMA PRA Category 1 Credit(s)™*.

Date Completed: March 9th, 2013
Maximum Credits: 1

Score: 100

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

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

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

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

Barry M. Manuel, M.D.
Associate Dean

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

My current NPI is: 1 7 0 0 0 1 2 4 5 7

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature: _____ Date: 04 /02 /2013

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Sarah Helene Averbach, MD
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature

04/02/2013
Date of Signature

Averbach, Sarah Helene
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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

MEDICARE/TAX FORM

INSTRUCTIONS:

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

I, Sarah Helene Averbach
(type or print name)

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

SIGNED: _____ DATE: 04/02/2013

Social Security Number: _____

****

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

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

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

SIGNED: _____ DATE: 04/02/2013

Sarah H. Averbach, MD

Beth Israel Deaconess Medical Center
330 Brookline Ave, KS 317; Boston, MA 02215
(617) 667-2285

POSTDOCTORAL TRAINING

06/2009-06/2013 **Beth Israel Deaconess Medical Center, Boston, MA**
Resident, Obstetrics and Gynecology, Harvard University

EDUCATION AND TRAINING

08/2004-06/2009 **University of California, San Francisco School of Medicine**
Doctor of Medicine, (MD with Thesis program)
Area of Concentration: Global Health

09/1999-06/2003 **University of California, San Diego, La Jolla CA**
Bachelor of Arts, Third World Studies
Honors, *magna cum laude*

ACADEMIC APPOINTMENTS

06/2009-06/2013 **Clinical Fellow**, Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School

07/20013-present **Instructor**, Obstetrics and Gynecology Harvard Medical School, Beth Israel Deaconess Medical Center

7/2013-present **Staff Physician**, Bowdoin Street Health Center, Dorchester, MA

LICENSURE AND CERTIFICATION

01/2012 Society of American Gastrointestinal and Endoscopic Surgeons: Fundamentals of Laparoscopic Surgery

09/2007-06/2008 UCSF School of Medicine Certificate Program in Bio-medical Research

PEER ELECTED LEADERSHIP POSITIONS

06/2012-06/2013 **Coordinating Chief Resident**, Beth Israel Deaconess Medical Center

06/2008-06/2009 **National Coordinator,** Medical Students for Choice

AWARDS AND HONORS

06/2012	Resident research day - runner up	Beth Israel Deaconess Medical Center
09/2007-06/2008	Clinical Research Fellow	Doris Duke Foundation
06/2001-06/2002	Public Service Grant	Donald A Strauss Foundation

MAJOR COMMITTEE ASSIGNMENTS

06/2012-present Member: Quality Assurance Committee, Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center

06/2012-present Member: Obstetrics Leadership Committee, Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center

06/2012-present Member: Gynecology Leadership Committee, Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center

INVITED PRESENTATIONS:

Grand Rounds, Dept. of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Boston, MA. "Immediate Postpartum IUD Insertion" June 2012.

Grand Rounds, Dept. of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Boston, MA. "Obstetrical care for the HIV positive patient" December 2012.

Grand Rounds, Dept. of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Boston, MA. "Termination of Pregnancy for Fetal Anomalies" March 2013.

BIBLIOGRAPHY

ORIGINAL PEER REVIEWED PUBLICATIONS:

Averbach S, Hacker M, Merport Modest A, Yiu T, Dimitrakoff J, Ricciotti R. The association between *Mycoplasma genitalium* and preterm delivery at an urban community health center. *In Press International Journal of Gynecology and Obstetrics*. March 2013.

Scott J, **Averbach S,** Merport Modest A, Hacker M, Cornish S, Spencer D, Murphy M, Parmar P. An assessment of gender inequitable norms and gender-based violence in South Sudan: a community-based participatory research approach. *Conflict and Health* 2013, 7:4

Averbach S, Gravitt P, Nowak R, Celentano D, Dunbar M, Grimes B, Morrison C, Padian N. The effect of cervical HPV infection on HIV acquisition among women in Zimbabwe: *AIDS*. 2010 Apr 24;24(7):1035-42.

Averbach S, Wendt J, Levine D, Philip S, Klausner J. Increasing Access to Plan B through Online Prescription Requests. *J Reprod Med.* 2010 Mar-Apr;55(3-4):157-60

Averbach S, Sahin-Hodoglugil N, Chipato T, Mushara P, van der Straten A. Duet for menstrual protection: a feasibility study in Zimbabwe. *Contraception* 2009;79(6):463-8.

BOOK CHAPTERS:

Stubblefield P, **Averbach S**, Grimes D. Septic Abortion: Prevention and Management. *Glob. libr. women's med.,(ISSN: 1756-2228)* 2012; DOI 10.3843/GLOWM.10438

REPORTS:

Scott J, **Averbach S**, Merport A, Hacker M. Gender-based violence in South Sudan, an assessment of gender norms 2009-2011. Prepared on behalf of the American Refugee Committee (ARC) and Harvard Humanitarian Initiative (HHI). Funded by: United Nations Population Fund (UNFPA). Submitted to ARC and HHI January 2012.

ABSTRACTS:

Lester F, **Averbach S**, Fortin J, Byamugisha J, Goldberg A, Kakaire O. Acceptability of intracesarean insertion of the Copper-T 380A in Kampala, Uganda. Poster presentation, Society of Family Planning, North America Forum on Family Planning. Denver, Colorado. October 29, 2012. Published as an abstract in *Contraception* Volume: 86, Issue: 3, Pages: 318 to 318

Lester F, **Averbach S**, Kakaire O,Fortin J, Byamugisha J, Goldberg A. Intracesarean insertion of the Copper T 380A vs 6-week post-cesarean insertion: an RCT. Poster presentation, FIGO World Congress of Gynecology and Obstetrics. Rome, Italy. October 7-12, 2012. Published as an abstract in the *International Journal of Gynecology & Obstetrics* Vol. 119 Supplement 3, Pages S578-S579

Scott J, **Averbach S**, Merport A, Hacker M. An Assessment of Gender Equitable Norms in South Sudan. Poster presentation, Women's Health 2012: The 20th Annual Congress. Washington, DC. March 16, 2012.

Yiu Y, **Averbach S**, Hacker M, Ricciotti H. The association between Mycoplasma genitalium and preterm delivery at an urban community health center. Poster presentation, Women's Health 2012: The 20th Annual Congress. Washington, DC. March 16, 2012.

Averbach S, Sahin-Hodoglugil N, van der Straten A. Duet for menstrual protection: A feasibility study in Zimbabwe. Poster presentation, Annual Meeting of the American Public Health Association, San Diego California. October 29, 2008.

Averbach S, Vaucher Y. An Ethno-medical approach for understanding pelvic organ prolapse in Eastern Nepal. Poster presentation, International Health and Medical Education Consortium (IHMEC) Annual conference, Antigua Guatemala. February 16, 2004.

INTERNATIONAL MEDICAL EXPERIENCE

4/ 2012 – 5/2012 **Nyaya Health International, Bayalpata Hospital, Achham Nepal**
Worked in a community health clinic in rural Nepal for 6 weeks as a clinical consultant. Spent time working with the health assistants, antenatal nurse midwives, and physicians on site to improve obstetric and gynecologic services offered to women. This included a lecture series, clinical consulting, and consulting with the surgical development team to develop an operating theater which suits the needs of surgeons. Continue to serve as a consultant for obstetrical and gynecologic cases.

3/2011-4/2011 **Mulago Hospital, Kampala Uganda**
Worked as an OB-GYN resident evaluating patients in clinic, rounding on in-patients, and assisting in surgery. Worked as an investigator on a randomized controlled trial evaluating Immediate post-placenta insertion of the Copper T 380A after cesarean delivery vs 6 week post-delivery interval insertion.

09/2007-06/2008 **UCSF-University of Zimbabwe Harare, Zimbabwe**
Received a competitive Doris Duke Charitable Foundation clinical research fellowship. Designed a case-control study (nested within a larger study that examined the effect of hormonal contraception on HIV acquisition) to evaluate cervical HPV infection as a risk factor for heterosexual acquisition of HIV infection among women in Zimbabwe. Responsible for study implementation, developing and obtaining IRB approval, some lab testing and analysis, and writing up the final paper. Lived and worked in Zimbabwe for one year during a period of economic and political instability. While in Zimbabwe also worked as a clinical coordinator for a phase 1 trial of Duet, a vaginal microbicide gel loaded in a cervical barrier, being studied for use in the prevention of HIV/STI transmission, as a contraceptive, and for menstrual protection.

07/2008-08/2008 **Sama Tiga, Aceh Sumatra Indonesia**
Integral member of a field team caring for tsunami survivors living in the United Nations tent camp in Sama Tiga, Aceh for internally displaced families. Provided prenatal care to pregnant women living in the camp city. Designed and conducted a health seminar on managing postpartum hemorrhage in a low-resource settings with traditional birthing attendants. Mentored by Robin Lim, Indonesian Midwife and CNN Hero of the year 2011.

October 2001- May 2002 **Helping Hands Health Clinic, Khandbari Nepal**
Initiated the establishment of a women's health clinic in rural Nepal. Purchased the initial equipment and supplies needed for a clinic and operating room with a public service grant from

the Donald Strauss Foundation. Participated in the first surgical camp in the new renovated operating room. Participated in selecting surgical patients and in the post-op care of surgical patients.

COMMUNITY SERVICE

06/2010-06/2012 **Dimock Community Health Center**, Ob/Gyn Clinic, Boston, MA
A Title 10 funded Community Health Center for Boston's Urban Underserved

09/2004-06/2006 **Tenderloin AIDS Resource Center**, San Francisco, CA
A medical student-run urgent care clinic and clean needle exchange for the urban underserved in San Francisco's Tenderloin district.

SUPPLEMENT FORM

PRINT NAME: Sarah Helene Averbach, MD DATE: 04 /02 /2013

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

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

Applicant's Signature: _____ Date: 04 /02 / 2013

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

Applicant's Signature: _____ **Date:** 04 /02 /2013

CONFIDENTIAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplemental pages for questions #16 to 18. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

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

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

Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).

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

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

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

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

I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

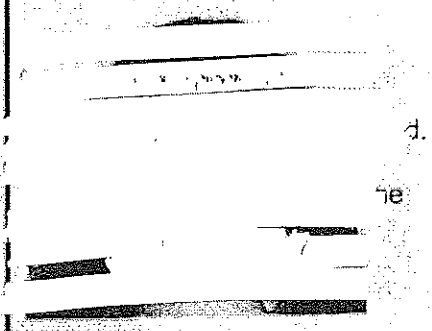
Applicant's Signature: _____ Date: 04 /02 /2013

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for a substantial period of time and is not a relative should execute this statement. The *Board of Registration in Medicine prefers statements from physicians licensed to* practice in Massachusetts.

PHOTOGRAPH



Signature of applicant

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

Signature of Notary

10/31/2014
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Sarah Alexbach
(name of applicant)

for 4 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of Certifying Physician

786155 License Number

MA State

Type or print name clearly

Address: 330 Brookline Ave
City: Boston
State: MA Zip: 02215
Telephone: (617) 667-2285
Date: 3/11/13

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

3/4/13
PA

From: Harvey, Frances
To: Thornton, Marion (MED)
Subject: RE: Medical Education Verificaton form for Dr Sarah Averbach
Date: Wednesday, April 17, 2013 1:10:57 PM

Hello Marion,
It's my pleasure to be of any assistance in this matter. Dr. Averbach's official date of graduation is June 12, 2009. This is the date that is on both transcript and diploma. Dr. Averbach completed all requirements for the MD degree on May 15, 2009, but the UC system uses the end of Spring quarter to mark graduation. For purposes of fulfilling limited licensing requirements in the state of Massachusetts, we provide this date prior to the graduation date. All of our MD graduates fulfill requirements a full month before their official grad dates and are advised to use the June date as it is the date that appears on all official documentation going forward.

Please don't hesitate to contact me regarding any/all inquiries regarding UCSF students. We are eager to make this frenetic time of year a little easier on everyone.

Best regards,
Frances Harvey
UCSF, School of Medicine
UME, Student Services
415-476-1216

From: Thornton, Marion (MED) [mailto:marion.thornton2@state.ma.us]
Sent: Wednesday, April 17, 2013 9:52 AM
To: Harvey, Frances
Subject: Medical Education Verificaton form for Dr Sarah Averbach

Hello Frances

Thank you so much for taking my phone call. Per our phone conversation, please confirm which date is correct for her last date of attendance, 5/15/09 which was submitted with her Limited License, or 6/12/09 which was submitted on our form for her Full License Application.

Thank you

Marion Thornton
Licensing Analyst
Board of Registration in Medicine
200 Harvard Mills Square Suite 330
Wakefield, MA 01880
Phone 1-781-876-8236 Fax 1-781-876-8383

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

MEDICAL EDUCATION VERIFICATION

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

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

Applicant's Signature: [signature] Date of Birth __

Print or Type Name: Avenbach (Last name) Sarah (First Name) H (Middle Initial) Social Security No: __

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

Name of Medical School: University of California, San Francisco

Address: 500 Parnassus Ave MU-200W City: San Francisco State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) to the applicant in a sealed envelope with the medical school seal affixed across the back of the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of medical school was different from the above named medical school when the 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 California, San Diego

Undergraduate School Address: San Diego, CA

(Continued on page 2)

Enrollment and Participation: Our records indicate that

Averbach (Last name) Sarah (First name) H (Middle initial)

(type or print the applicant's name):

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 27 / 04	06 / 15 / 05	07 / 01 / 07	06 / 30 / 08
	09 / 01 / 05	06 / 30 / 06	07 / 01 / 08	06 / 12 / 09
	07 / 01 / 06	06 / 30 / 07	/ /	/ /

The applicant attended 158 total weeks *or* _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one [XX] was awarded a degree in Medicine (M.D.) on (month/day/year) 06 / 12 / 2009

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

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

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Was the medical school education more than 4 years for U.S. graduates or more than 6 years for international graduates?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Maxine Papadakis

Print Name: Maxine Papadakis, MD

Title: Associate Dean for Students

Date: 3 / 15 / 2013 Telephone: (415) 476-1216

E-mail address: _____

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 sealed envelope. Thank you

4/4/13

PM

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

MAXINE PAPADAKIS, M.D.
ASSOCIATE DEAN FOR STUDENTS
SCHOOL OF MEDICINE
UNIVERSITY OF CALIFORNIA
SAN FRANCISCO

513 PARNASSUS AVENUE, S-245
SAN FRANCISCO, CALIFORNIA 94143-0454
TEL: (415) 476-1217
FAX: (415) 502-1320
E-MAIL: PAPADAKM@MEDSCH.UCSF.EDU

Marcy 15, 2013

RE: Sarah Helene Averbach, MD

This is to certify that SARAH HELENE AVERBACH entered the UC-San Francisco School of Medicine on August 27, 2004. After completing her third year of medical school, Ms. Averbach extended her education by one year to accept one of approximately 60 national Doris Duke Foundation Clinical Research Fellowships. Along with the yearlong research experience, fellows participate in a structured didactic program comprised of the Designing Clinical Research course for physician-scientists, the UCSF School of Medicine's Certificate Program in Biomedical Research, and the MD with Thesis program; students who complete a thesis based on their work qualify for MD with Thesis distinction upon graduation. Ms. Averbach returned to clinical studies and was awarded the M.D. degree on June 12, 2009.

If you have any questions regarding Dr. Averbach's medical education, please contact my office.

Sincerely,

Maxine Papadakis

Maxine Papadakis, M.D.
Associate Dean for Students

MP:fh

Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that Sarah Averbach
(Student's Name)

has completed the requirements for the XXX M.D. degree ☐ D.O. degree

from University of California, San Francisco
(Name of Medical School)

and will receive the degree on 6/12/2009.

Signature of Certifying Official: Maxine Papadakis MD
(Original Signature is required – Stamps not accepted)

Printed Name: Maxine Papadakis, MD

Title: Associate Dean for Student Affairs

Date: May 15, 2009

Please return the completed Form B to the Limited License Coordinator, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - Telephone: (781) 876-8210 Fax: (781) 876-8383. Thank you

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/11/13

Print or Type Name: Sarah Averbach

Name of Institution: Beth Israel Deaconess Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Beth Israel Deaconess Medical Center If name of institution was different when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that Sarah Averbach (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
intern	1	OB/GYN	6/22/09	6/22/10	Yes	ACGME
Residency	2	OB/GYN	6/23/10	6/22/11	Yes	ACGME
Residency	3	OB/GYN	6/23/11	6/22/12	Yes	ACGME
Residency	4	OB/GYN	6/23/12	6/14/13	NO	ACGME

(Continued on page 2)

APPLICANT'S NAME: Sarah Auerbach

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

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

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

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: Hope Riccioni, MD

Academic Title: Acting Chair OB GYN / Program Director

Telephone: 617-667-2285 Today's Date: 3/11/13

E-mail address: hriccio@bidmc.harvard.edu

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

4/4/13
cm

FULL LICENSE APPLICANT

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

EVALUATION FORM

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: [signature] Date: 3/11/13

Please PRINT your name Sarah Averbach

Name of facility: Beth Israel Deaconess Medical Center State MA

INSTRUCTIONS TO THE CHIEF OF SERVICE OR PROGRAM DIRECTOR WHO MUST BE A PHYSICIAN: Please complete the questions below and return to the applicant with your name affixed across the envelope seal.

1. How long have you known the applicant? From: 6/22/09 To: ~~6/14/13~~ 4/18/13 HAR 4/18/13

   A. In what capacity? ☑ supervisory ☐ colleague ☐ affiliated in practice ☐ other: _____

   B. Date(s) of applicant's affiliation at facility: From: 6/22/09 To: ~~6/14/13~~ 4/18/13 HAR 4/18/13

   C. Applicant's Status: ☑ ~~Intern~~ ☑ ~~Resident~~ ☐ Fellow ☐ Staff Member ☐ Other _____

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? ☑ No ☐ Yes (if "yes" please explain below)

   _____

   _____

3. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on the back of this evaluation and/or attach 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)

4. 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. ☑ NO ☐ YES

5. PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.

Dr. Averbach is an outstanding OB/GYN resident

6. The above comments are based on the following:

☑ Close personal observation

☐ General impression

☑ A composite of previous evaluations by other physicians

☐ Other _____

7. RECOMMENDATIONS:

☑ I recommend Sarah Averbach for licensure in Massachusetts.

☐ I recommend _____ for licensure in Massachusetts, with the following reservations

_____

☐ I do not recommend _____ for licensure in Massachusetts

Signature: _____ (check one) ☑ M.D. or ☐ D.O.

Print Your Name: Hope Ricciotti Date: 3/11/13

Academic title or position: Acting Chief Phone number: 617-667-2285

Specialty/Service or Department: OB/GYN

E-mail address: hricciot@bidmc.harvard.edu

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Sarah H Averbach, M.D. **License No.:** 241196

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Avenue
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 241196

5. **Other states where you are now licensed to practice medicine**
   None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? Yes

Has the physician been subject to past or pending disciplinary action in this Program?

Name: Martina DiNapoli **Date:** 1/24/2012
Designation: Residency Coordinator **Telephone:** (617) 667-2285

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Sarah H Averbach** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Lynnette Cheseborough **Date:** 1/24/2012
Designated Official's Title: GME Coordinator **Telephone:** (617) 667-3210

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

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

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Sarah H Averbach, M.D. **License No.:** 241196

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Avenue
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 241196

5. **Other states where you are now licensed to practice medicine**
   None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? Yes

Has the physician been subject to past or pending disciplinary action in this Program?

Name: Susan Herlihy Kilbride **Date:** 2/22/2011
Designation: Medical Education Manager, OBC **Telephone:** (617) 667-2966

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Sarah H Averbach** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Lynnette Cheseborough **Date:** 2/23/2011
Designated Official's Title: GME Coordinator **Telephone:** (617) 667-3210

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

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

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Sarah H Averbach, M.D. **License No.:** 241196

1. **Training Program**

   Current Training Program

   Facility: Beth Israel Deaconess Medical C
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Beth Israel Deaconess Medical Center
   330 Brookline Avenue
   Boston
   Massachusetts - 02215
   United States of America

   Home Address:
   19 Bucknam Street
   Apt #1
   Boston
   Massachusetts - 02120
   United States of America
   (585) 531-7272

3. **Email Address:** saverbac@bidmc.harvard.edu

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 241196

5. **Other states where you are now licensed to practice medicine**
   None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? Yes

Has the physician been subject to past or pending disciplinary action in this Program?

Name: Keilah Santana **Date:** 3/22/2010
Designation: Residency Coordinator **Telephone:** (617) 667-2285

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Sarah H Averbach** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Susan Herlihy Kilbride **Date:** 3/22/2010
Designated Official's Title: Administrative Director **Telephone:** (617) 667-9501

6-A. Have you been terminated, granted a leave of absense, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

16. Have you been charged with any criminal offense, other than a minor traffic offense?

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

Compliance with Legal Responsibilities

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

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

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

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

[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.**

Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that Sarah Averbach
(Student's Name)

has completed the requirements for the XXX M.D. degree ☐ D.O. degree

from University of California, San Francisco
(Name of Medical School)

and will receive the degree on 6/12/2009.

Signature of Certifying Official: Maxine Papadakis MD
(Original Signature is required – Stamps not accepted)

Printed Name: Maxine Papadakis, MD

Title: Associate Dean for Student Affairs

Date: May 15, 2009

Please return the completed Form B to the Limited License Coordinator, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - Telephone: (781) 876-8210 Fax: (781) 876-8383. Thank you

TS 5/11/09
ck# 1169

08/13/09 $2

MAY 08 2009

Board of Registration in Medicine

Application #: 241196

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

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE: ☒ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
☐ Graduate of an International Medical School (IMG)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) Averbach (First) Sarah (MI) H

1-B. Other Name(s): _____

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

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

2. Current Address: _____ Telephone Number: _____
City: _____ State: _____ Zip: _____

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

E-mail Address _____

4. Sex: ☐ Male ☒ Female 5. Social Security Number: _____

6. Name of Massachusetts Training Program: Beth Israel Deaconess Medical Center

330 Brookline Ave Kirstein 317 Boston MA 02215
Street Address (City)

08/13/09 83

PRINT NAME Sarah H Averbach

7. Name of premedical school(s): University of California, San Diego
Location: La Jolla, CA USA
(City, State, Country)

8. Name of medical school(s): University of California, San Francisco
Location: San
(City, State, Country)
Date of Graduation: 06 / 12 / 09 Degree: ☒ M. D. ☐ D. O. Other (specify)_____
(Month) (Day) (Year)
(See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? ☒ No ☐ Yes
Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____

Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *ever* had a license to practice medicine (include residency training licenses).
_____ ☐(Full) _____ ☐ (Full) _____☐ (Full) _____☐(Limited) _____ ☐ (Limited)

11. Please indicate **all** the licensing examinations that you have have completed with a passing score:

USMLE ☒ Step 1 ☒ Step 2 (CK) ☐ Step 2 (CS) ☐ Step 3

NBME ☐ Part 1 ☐ Part II ☐ Part III ☐ COMLEX ☐Level 1 ☐Level 2 ☐ LMCC

	YES	NO
12-A. If you are a USMG, have you taken more than 4 years to complete medical school?	☒	☐
12-B. If you are an IMG, have you taken more than 6 years to complete medical school? If **yes**, you must provide additional information. (See instructions).	☐	☐
13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?	☐	☒

If **yes**, you must provide additional information with your curriculum vitae and include the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

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

This certifies that Sarah Auerbach has been appointed
(Name of Applicant)

to the position of ☒ Intern ☐ Resident ☐ Fellow

in the specialty of Obstetrics + Gynecology as a PGY 1

Department: OBSTETRICS + GYNECOLOGY Subspeciality: OB/GYN

at Beth Israel Deaconess Medical Center
(Name of Healthcare Facility)

beginning 06 / 22 / 09 to anticipated completion of training: 06 / 30 / 13.
(Month) (Day) (Year) (Month) (Day) (Year)

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

Designated Official's Signature: [signature]

Type or Print Name: Lynnette Cheseborough

Official Title: Administrative Assistant II

Date: 4 / 23 / 2009 Telephone Number: 617. 667. 3210

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

PRINT NAME: Sarah H Averbach

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

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

PRINT NAME: Sarah H Averbach

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

08/13/09 83

PRINT NAME: Sarah Averbach

CONFIDENTIAL MEDICAL INFORMATION

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

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

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

CERTIFICATIONS:

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license application and all its accompanying instructions, forms and statements, and to the best of my knowledge, and belief, the information contained herein is true, correct and complete. As an applicant for a limited 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.

Applicant's Signature: Sarah Averbach **Date:** 03/24/09

12-A Extended Medical School Beyond 4 years:

I completed my core medical school curriculum in the standard 4 years time. I extended my studies by one year, however, in order to do a Doris Duke Research Fellowship between the third and fourth years of medical school. I spent this year in Zimbabwe where I worked on a study evaluating a vaginal microbicide gel loaded in a cervical barrier as a dual method for use in the prevention of HIV/STI transmission and as a contraceptive. I also conducted a study examining whether cervical HPV infection is a risk factor for HIV acquisition among women. This work was the basis of my Thesis for which I received an MD with Thesis notation.

Limited License

08/12/09 SD 11

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Sarah Helene Averbach
(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 Telephone: (781) 876-8210 Fax: (781) 876-8383
www.massmedboard.org 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.

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.

Sarah Averbach — Applicant's Signature

03/24/09 — Date of Signature

Averbach, Sarah H. — Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Curriculum Vitae

Date Prepared: March 24, 2009

Name: Sarah Averbach, MD

Office Address: Beth Israel Deaconess Medical Center
330 Brookline Ave, Kirstein Suite 317
Boston, MA 02215

Home Address.

Work Phone: (617)-667-4173

Work E-Mail:

Work FAX: (617)-667-4173

Place of Birth:

Education

09/1999-05/2003 BA Third World Studies University of California, San Diego
Honors, *magna cum laude*

09/2004-06/ 2009 MD University of California, San Francisco
MD with Thesis

Postdoctoral Training

06/2009-06/2013 Resident Physician OB/GYN Beth Israel Deaconess Medical Center, Harvard University

Major Administrative Leadership Positions

04/2008-04/2009 National Coordinator /Board of Directors Medical Students for Choice

Professional Societies

2008-present American Public Health Association
2003-present Global Health Education Consortium

Honors and Prizes

2005-2008	Osher Scholar	Bernard Osher Foundation
2007-2008	Clinical Research Fellow	Doris Duke Foundation
2005	International Health Scholarship	Rainer Fund
2001-2002	Public Service Grant	Donald A Strauss Foundation

Funding Information

09/2007-06/2008 Co-investigator Reprotect, Inc
Duet for Menstrual Protection
This was a feasibility study evaluating a new cervical barrier as a menstrual protection device. Responsibilities included drafting the proposal, IRB, operating manual, and all study instruments.

09/2007-06/2008 Study Co-coordinator International Partnership for Microbicides
Acceptability of Duet Among African women for the Prevention of HIV transmission
This is an ongoing Phase 1 trial evaluating the safety and acceptability of the DUET (a cervical barrier loaded with the vaginal microbicide Buffergel) to prevent STI transmission and as a contraceptive. Responsibilities included administration coordination of field work and study budget.

Community Service

09/2007-05/2008 Intern UZ-UCSF's Comprehensive Abortion Care Advocacy Project
Harare, Zimbabwe
Assisted with Grant writing for a large UN/WHO funded initiative exploring the potential for expanded provision of medical abortion by nurse-midwives in rural and urban Zimbabwe

10/2004-04/2006 Clinic Volunteer TARC
San Francisco, CA
Volunteered at the medical clinic at the Tenderloin Aids Resource Center— A student-run urgent care clinic for the urban underserved.

06/2005-08/2005 Clinic Volunteer Bumi Sehat
Sumatra, Indonesia
Integral member of a field team caring for tsunami survivors living in the UN refugee camp

06/2005-08/2005 Rainer Fellow Bumi Sehat
Sumatra, Indonesia
Community Health Project : Preventing Maternal Mortality in Low resource
Designed and conducted a health seminar on managing postpartum hemorrhage in a low-resource settings with traditional birthing attendants.

09/2001-06/2002 Strauss Scholar Helping Hands
San Francisco, CA
Initiated the establishment of a women's health clinic in rural Nepal

Publications

Averbach, S., Sahin-Hodoglugil, N.,Chipato, T., Mushara, P., van der Straten, A. Duet for menstrual protection: a feasibility study in Zimbabwe. *Contraception* (in press).

Thesis

The effect of cervical HPV infection on HIV acquisition among women in Zimbabwe: a case-control study. Advisor: Nancy Padian, PhD MPH

08/13/09 S2 15

DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physician's Name: Sarah (First Name) H. (Middle Initial) Averbach (Last Name)

is applying for a limited license in Massachusetts. I received and opened the documents listed below that were sent to me by the physician in sealed envelopes or directly from the primary source:

- [x] Medical school verification form
- [x] Medical school transcripts
- [ ] Letter from program director
- [ ] Evaluations
- [ ] Leave of absence
- [x] Other documents (describe): Letter of explanation from school

I hereby certify under the penalties of perjury that I have not altered the attached documents and they are forwarded to the Board of Registration in Medicine, with the original envelopes attached, as received by me.

Designated Official: [signature] Date: 5.7.09

Title: Administrative Assistant II

Name of Institution: Beth Israel Deaconess Med Ctr.

NOTE: **Malpractice complaints, dismissals and other legal documents must be sent directly to the Board of Registration in Medicine from the primary source.**

Affix institutional seal or if the institution does not have a seal, this form must be notarized.

Zip/Limitedrelease/2

LIMITED LICENSE APPLICANT – FORM A

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

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: Sarah Averbach Date of Birth _____

Print or Type Name: Averbach (Last name) Sarah (First Name) H (Middle Initial) Social Security No:

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

Name of Medical School: University of California, San Francisco

Address: _____ City: San Francisco State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above named applicant has not been awarded a degree. 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? [X] Yes [ ] No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of California, San Diego

Undergraduate School Address: San Diego, CA

Continued on page 2

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	Averbach (Last name)	Sarah (First name)	H. (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 27 / 04	6 / 15 / 05	07 / 01 / 07	06 / 30 / 08
	09 / 01 / 05	6 / 30 / 06	07 / 01 / 08	05 / 15 / 09
	09 / 01 / 06	6 / 30 / 07	/ /	/ /

The applicant attended 152 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one ☐ was awarded a degree in _____ on (month/day/year) ____/____/____

☒ will be awarded on 6 / 12 / 09 **(Form B must also be completed and returned directly to the Board)**

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

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

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Marine Papadakis

Print Name: M. Papadakis, MD

Title: Associate Dean, Student Affairs

Date: 03 / 26 / 09 Telephone: (415) 476-1216

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

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE
OFFICE OF STUDENT AFFAIRS

513 PARNASSUS AVENUE, S-245
SAN FRANCISCO, CALIFORNIA 94143-0454
TEL: (415) 476-1216
FAX: (415) 476-0714

March 18, 2009

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

RE: Sarah Averbach

This is to certify that SARAH AVERBACH entered the University of California, San Francisco School of Medicine on August 27, 2004. After completing her third year of medical school, Ms. Averbach extended her education by one year to accept one of approximately 60 national Doris Duke Foundation Clinical Research Fellowships. She then returned to clinical training and is expected to graduate with a degree in medicine on June 12, 2009.

Please contact my office at (415) 476-1217 if you need additional information about Ms. Averbach's enrollment at UCSF.

Sincerely yours,

Maxine Papadakis

Maxine Papadakis, M.D.
Associate Dean for Student Affairs

MP/fh