



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

Physician Registration Renewal Application

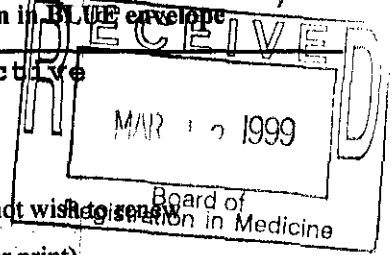
Before proceeding, please read the instruction booklet.

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

- Remit \$250.00 for renewal fee.
- Add late fee of \$25.00, if necessary.

- Return renewal application in **GREEN** envelope.
- Enclose check with coupon in **BLUE** envelope.

Registration No.: **151665** Renewal Date: **04/26/1999** 1. Current Status: **Active**



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

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

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

Please make corrections (type or print)

3. A) Mailing/Business Address:

IRINA NATAPOV, M.D.

Other Name(s): IRINA NATAPOV, M.D.

Mailing Address: 34 STATE STREET
 City/Town: LYNN State: MA
 Zip: 01901 Country: USA

B) Home Address:

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

Home Phone: _____
 Business Phone: **(978) 741-1200**

Home: _____
 Business: **(781) 581-6181**

4. A) Date of Birth: _____ Sex: **F**
 B) SS#: _____

Date of Birth: (M/D/Y): 1/1 Sex: M F
 SS#: _____

5. A) Name of Medical School:
**MOSCOW MED STOMATOLOGIC INST,
 MOSCOW, RUSSIA**

Full Name of Medical School: _____

B) Year Graduated: **1976** C) Degree: **MD**

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

6. Specialty Code(s) (See Table 1)
 Code(s) 011 Hours per Week in Mass. 0
OBG 0 Obstetrics and Gynecology

Code(s) _____ Hours Per Week in Massachusetts _____

If OS, Print Specialty: _____

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

Code: _____ Code: _____

8. Drug License Number

Federal (DEA): _____
 Mass: _____

- A) Federal (DEA):
- B) Massachusetts:

9. A) Other states where you are now licensed to practice

Abbr: _____

Abbr: _____

B) States where you previously were licensed to practice

Abbr: _____

Abbr: _____

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



PRINT NAME AND NUMBER: Last Name: NATAPOV Registration Number: 151665

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS:

YES NO

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Inna Natapov Date: 3/10/99

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING



CURRICULUM VITAE

IRINA NATAPOV. M.D.

Phone

EDUCATION:

- 1970-1976 Moscow Medical and Dental School, Moscow, USSR.
(Moscow Medical Stomatological Institute)
- 1976-1977 Internship in Internal Medicine., Moscow City Hospital #36, Moscow, USSR.
- 1977-1979 Fellowship in Internal Medicine/Primary Care. Moscow City Hospital. Moscow, USSR.
- 1985-1987 Fellowship in OB/GYN. Department of OB/GYN,. Moscow Maternity Hospital #25. Moscow, USSR.
- 1994-1996 Residency in Internal Medicine/Primary Care, Salem Hospital, Salem, MA, USA.

WORK EXPERIENCE:

- 1979-1985 Staff Physician. Department of Primary Care. Moscow City Hospital #81, Moscow, USSR.
- 1987-1989 Staff OB/GYN. Department of Surgery and OB/GYN, City Hospital, Moscow, USSR.
- 1993 Preceptorship at MetroWest Medical Center, Framingham, MA, USA.
/two months /
- 1993 Preceptorship at Carney Hospital, Boston, MA, USA
/one month /

CERTIFICATION AND LICENSE:

- 1976 Doctor of Medicine, Moscow, USSR.
- 1987 Diploma, State Board of OB/GYN, Moscow, USSR
- 1991 Diploma, Educational Commission for Foreign Medical Graduates (Part 1).
- 1992 Diploma, Educational Commission for Foreign Medical Graduates (Part 2).
- 1992 Diploma, FLEX (Component 1).
- 1993 Diploma, FLEX (Component 2).

MEDICAL ASSOCIATIONS:

The Massachusetts Medical Society and AMA.

PERSONAL:

REFERENCES: Furnished upon request.



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

MR
3-25

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

The Board will charge a fee for each copy.

- Remit \$250.00 for renewal fee.
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

Handwritten signature

Registration No.: **151665** Renewal Date: **04/26/97**

1. Activity Status: Active Retiring (see instructions)
 Inactive *(see below) Do not wish to renew

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

3. A) Mailing/Home Address:

IRINA NATAPOV, M.D.

B) Business Address:

**SALEM HOSPITAL
8 HIGHLAND AVENUE
SALEM, MA 01970**

Home Phone:

Business Phone: **(508) 741-1200**

4. A) Date of Birth: C) Sex: **F**
 B) Lic. Issue Date: **09/25/96** D) SS#:

5. A) Name of Medical School:

**Moscow Med Stomatologic^{aL} Inst,
Moscow, Russia**

B) Year Graduated: **76** C) Degree: **MD**

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

Code(s)	Hours per Week in Mass.	
IM	0	Internal Medicine
OBG	0	Obstetrics and Gynecology

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

Code: Code:

8. Drug License Numbers, if any:

A) Federal (DEA):
 B) Massachusetts:

9. A) Other states where you are now licensed to practice

Abbr:

B) States where you previously were licensed to practice

Abbr:

RECEIVED RECEIVED

Other Name(s):	
Mailing Address:	
City/Town:	State:
Zip:	Country:
Other Address:	
City/Town:	State:
Zip:	Country:
Home: ()	
Business: ()	
Date of Birth (M/D/Y):	Sex (M/F):
Lic. Issue Date (M/D/Y):	SS#:
Full Name of Medical School:	
Year Graduated: Degree (MD/DO):	
Code(s)	Hours Per Week in Mass.
If OS, Print Specialty:	

Code:	Code:
-------	-------

Federal (DEA):
Mass:

Abbr:
Abbr:

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



To: Board of Registration in Medicine
10 West Street - 3rd floor
Boston, MA 02111

From: Irina NATAPOV, M.D.

To whom, it may concern,

At the present time I am applying for the full license in MA.

As you can see from my CV I graduated from medical school in Moscow, Russia in 1976 and was working as a physician until 1989.

In 1989 I immigrated to the US. I started to prepare for ECFMG exams and English test which takes 2 1/2 years until 1992, then I participated in NRMP in 1993-1994 and started my residency program in Salem Hospital in July 1994.

At the present time I am doing PGY III in Internal medicine / Primary Care in aforementioned hospital.

I hope you will find these explanations satisfactory.

If you have any further questions don't hesitate to call me: home ph-
business ph- (608) 741-1200

09.08.96.

Sincerely,

Irina NATAPOV
(Dr. Irina NATAPOV)



Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

TO ALL APPLICANTS

Massachusetts General Laws Chapter 62C, section 49A, requires that you complete this statement to obtain licensure to practice a profession.

I, Irina NATAPOV
Name

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

Date: 07.16.96 Irina Natapov
Signature

Social Security Number, Optional

Massachusetts General Laws Chapter 12, section 5, and 243 CMR 2.04(2)(k) require that you complete the following statement:

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

Date: 07.16.96 Irina Natapov
Signature

To: Board of Registration in Medicine
Ten West Street
Boston, MA 20111

From: Irina Natapov, M.D.

To whom it may concern,

I am not able submit any original documents on your request. I left Russia as a political refugee and was not allowed to bring any original documents.
I submit a photocopy of original marriage certificate and official translation.

07.19.1996

Sincerely,

A handwritten signature in cursive script, appearing to read "Irina Natapov".

Irina Natapov, M.D.

MARRIAGE CERTIFICATE

Name NATAPOV, BORIS DANILOVICH
Date of birth
Place of birth

Name LEVITEN, IRINA GEORGIEVNA
DATE of birth
Place of birth

Married December 29, 1979
Registered December 29, 1979.

Record # 2236

Names given after marriage to Husband NATAPOV
to Wife NATAPOVA

Place of registration Sevastopolsky District of
Moscow, Moscow, Russia.

Date of registration December 29, 1979

Stamp Chief of Marriage Bureau

VI MFO # 434414 Signature

This document was verified by:
Alla Brikman

Alla Brikman

Marilyn Dobrusin
Marilyn Dobrusin, Notary Public
my commission expires 9/26/97

Signed and sworn to before me
this 7 day of June, 1993



**JEWISH
VOCATIONAL
SERVICE**

DIPLOMA

B-I No. 430101

Refuge Programs
105 Chauncy Street
Boston, Massachusetts 02111
617 426-6990

This diploma is issued to **Irina Georgievna LEVITEN** to certify that she entered Moscow Medical and Dental School in 1970 and in 1976 completed the full program of said School majoring in the specialty of **General Medicine**.

I.G. LEVITEN was qualified as a **Physician** pursuant to the decision of the State Examination Board, dated June 25, 1976.

Chairman of the State Examination Board (signature)
Rector (signature)
Secretary (signature)

The city of Moscow, June 25, 1976
Registration No. 989
Seal

On this the 27 day of November
1989, personally appeared
A. Vasilevsky who swore that
this was an accurate translation
of the original document.

[Signature]
Russian Translator -- JVS

J. Alievsky July 1, 1994
Notary Public Commission expires

Irina Leviten
I, [Signature], My Commission Expires
subscribed to before me by [Signature] October 3, 1997
[Signature], whose identity
is known to me, this [Signature]
day of [Signature], 19[Signature]

President
Richard M. Rossman
Vice Presidents
Stephen Elmont
Frederic H. Goldstein
Helen K. Kass
Treasurer
Linda K. Pine
Assistant Treasurer
Howard [unclear]

Executive Director
Barbara Rosenbaum
Secretary
Joseph Garb
Assistant Secretary
James Gould

Board of Directors
Landra Asher
Andrea Axelrod
Gerald Bartfield
Roger Berkowitz
Rick Cohn
Andrew L. Eisenberg
Frimette Field
Mildred Flashman
Larry Franklin
Stanley N. Freedman

Ellen S. Heller
Robert Hoffman
Richard Horowitz
Alan N. Horwitz
David Jacobs
Arnold F. Kanack, Ph.D.
Mildred G. Kravetz
Neil D. Krug
Linda Lerner
Richard J. Levin
Douglas Okun

Jarome Rogoff, M.D.
Ellsworth E. Rosen
Michael Rukin
Michael I. Schwartzman
Melvin Scovell
Barbara Sherman
James Shulman
Harry L. Silverman
Michael Tichnor
Leona Zarsky, M.D.

Past Presidents
Hon. Herbert Abrams
Leo R. Breitman
Saul H. Dell
Leo Dunn
Clifton Heiman
Joseph S. Michelson
Louis Milerider
Burton J. Miller

Bartram R. Paley
Samuel Rabinowitz
Stephen M. Richmond
Hirsh Sharf
Harvey L. Solar
Solomon Stern
George M. Wolfe
Arthur Zanditon

Honorary Directors:
Henry Gorman
Norman A. Koss
Frances Levin
George Levy
Leon G. Nagre
Marshall Schneider
Max Seltzer
Harold Shapiro
David Troderman

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105
717-783-1400
717-787-2381
July 23, 1996

The Board of Registration in Medicine
Ten West Street
Third Floor
Boston, MA 02111

RE: NATAPOV IRINA

Dear Doctor:

DUE TO A SERIOUS FIRE WHICH PERMANENTLY DAMAGED THE BOARD'S RECORDS, WE ARE UNABLE TO PROVIDE FEDERAL LICENSING EXAMINATION (FLEX) RESULTS. IF YOU WOULD LIKE TO OBTAIN YOUR TEST SCORES, PLEASE CONTACT THE FEDERATION OF STATE MEDICAL BOARDS, 400 FULLER WISER ROAD, EULESS, TX 76039 OR CALL AT 817-868-4000.

THANK YOU FOR YOUR COOPERATION IN THIS MATTER.

SINCERELY,

STATE BOARD OF MEDICINE



Certification of Post-Graduate Training

FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, WAYNE Rebbin MD, Program Director Medical Residency SALEM HOSP

hereby certify that IRINA NATAPOV has served 2 year(s) of post-graduate training as a resident in INTERNAL MEDICINE at SALEM HOSPITAL, SALEM City, MASS State.

This program is [checked] is not approved by the ACGME or the RRC. Dr. NATAPOV participated in this program from 7 Month, 94 Year to Present, and was issued was not issued [checked] a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

Not yet completed TRAINING

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

Signature of Director: [Signature] Date: 7/26/96

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE TEN WEST STREET, 3RD FLOOR, BOSTON, MASSACHUSETTS 02111



Certification of Post-Graduate Training

FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, WAYNE JREBBIN MD, DIRECTOR INTERNAL MEDICINE RESIDENCY
Name Title SALEM MASS

hereby certify that IRINA NATAPOV has served 2 1/2 year(s)

of post-graduate training as a RESIDENT in INTERNAL MEDICINE
Position Specialty

at Salem Hospital, SALEM, MA.
Hospital City State

This program is is not approved by the ACGME or the RRC.

Dr. NATAPOV participated in this program from

7 Month, 94 Year to 7 Month, 97 Year and was issued was not

issued a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

will receive when completes training 7/97

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

Wayne Jrebbin MD
Signature of Director

9/14/96
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111



Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

✓ Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee \$50	Date	M.R.	Pr.	Bk.	Ch.	D.E.	F.
			95-074596				JKW	4/21/95	

Important:

- Read the accompanying instructions in their entirety before completing this form.
- Print legibly or type your answers.
- Answer all non-optional questions (front and back of form) completely—Even though the Board may have the information, it is not adequate to state that the Board already has the information.
- Sign the application at the bottom of page two.
- Make a copy of this form and all attachments for your own records—you must give hospitals and other health care facilities copies for credentialing purposes.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

- Name (LAST): NATAPOV (FIRST): IRINA (M.I.): _____
- Mailing Address: _____
- Name & Address of Training Hospital: Salem Hospital 89 Highland Ave, Salem MA 01970
- Medical School Name: Moscow Medical School
- Current Limited License Number: 94-0745-95
- To be completed by Program Director:

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes No

Type or Print Name and Title: Herbert L. Cooper MD Chief of Medicine

Signature of Program Director: [Signature]

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

This certifies that IRINA NATAPOV has been appointed to the position of Intern Resident

Fellow Int Medicine in Program Salem Hospital at Salem Hospital beginning 7/1/95 and

Anticipated completion date of training (Program) 6/30/96 (Institution)

This program is accredited by the ACGME: Yes No

If no, we have an ACGME approved training program in the applicant's specialty: Yes No

Designated Official's Signature: [Signature]

Type or Print Name and Title: H.L. Cooper MD, Chief of Medicine Date: 4/11/95

(Applicant See reverse side - You must complete Section C)

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice: (Abbreviate): none

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

Yes No/

- 15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? no
- 16. Have you been a defendant in any criminal proceeding other than a minor traffic offense? no
- 17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? no
- 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? no
- 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)? no
- 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? no
- 21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine? no
- 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? no
- 23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college? no
- 24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)? no

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.82C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: [Signature] Date: 04/04/95



THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: \$350.00 TO BE SUBMITTED

Filed: 7/27/96 For Office Use Application #
By: M Certificate # 151665 Date of Issue 9/25/96
Form of Fee: 350

Please Print SWORN STATEMENT Date: 07.16.96

Name IRINA Natapov Address _____
First Middle Last

Date of Birth _____

Place of Birth Russia

Name on Birth Certificate IRINA Leviten Phone # _____
Pre-Medical Education Medical Education

School High School # 625 Moscow School Moscow Medical and Dental School
Russia

Years Attended 10 (1960-1970) Years Attended 6 (1970-1976)

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

Place	Position	Dates
<u>Moscow City Hospital #36 USSR</u>	<u>internship</u>	<u>1976-1977</u>
<u>Moscow City Hospital</u>	<u>Russian Fellowship Int. med.</u>	<u>1977-1979</u>
<u>Moscow City Hosp # 81, Russia</u>	<u>Physician Primary Care</u>	<u>1979-1985</u>
<u>maternity Hosp #25 Russia</u>	<u>Fellowship in OB/GYN</u>	<u>1985-1987</u>
<u>City Hosp. Moscow Russia</u>	<u>Physician OB/GYN</u>	<u>1987-1989</u>
<u>metrowest med. Ctr, Framingham MA</u>	<u>preceptorship</u>	<u>1993 (2 mo)</u>
<u>Carney Hospit. Boston MA</u>	<u>preceptorship</u>	<u>1993 (1 mo)</u>
<u>Salem Hospital Salem MA</u>	<u>Med. Resident. PGY-2</u>	<u>1994-1995</u>
<u>Salem Hospital Salem MA</u>	<u>Med. Residency PGY-1</u>	<u>1995-1996</u>

Is this your first full license? yes If applicable, please list all other states where you are or have been licensed:

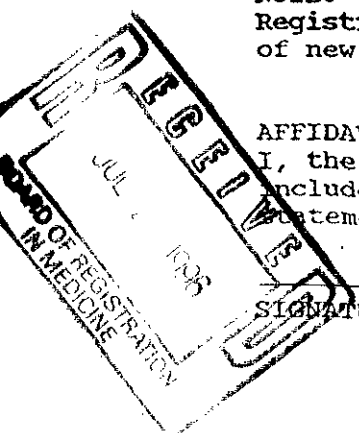
Other names under which you have been licensed:
Irina Georgievna Leviten

List Specialty Boards by which you are certified: no

REASON APPLYING FOR A MA LICENSE moonlighting
Anticipated starting date if you have position pending in Massachusetts: 9/1/96

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

AFFIDAVIT OF APPLICANT:
I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.
Irina Natapov Date: 07/16/96
SIGNATURE OF APPLICANT



COMMONWEALTH OF MASSACHUSETTS
COUNTY OF ESSEX

September 6, 1996

appeared before me, Irina Natafov, who stated that this document is a true copy of the original as seen by me.

Irina Natafov

Randolph E. Goodwin

Randolph E. Goodwin
Notary Public
My Commission Expires April 7, 2000

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

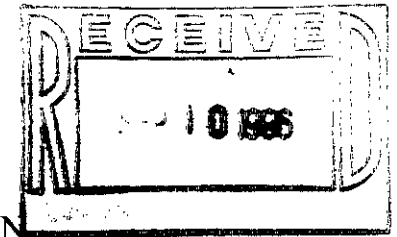
CERTIFIES THAT

IRINA NATAPOV

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.



CERTIFICATE NUMBER 0-451-587-0

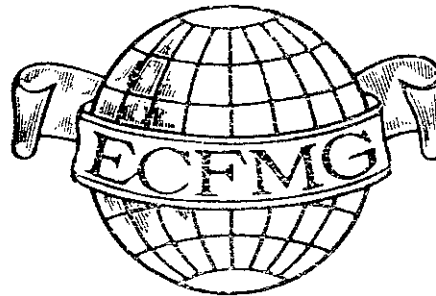
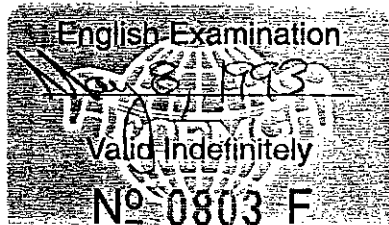
MEDICAL EXAMINATION

BASIC SCIENCE JULY 23, 1991

CLINICAL SCIENCE JULY 22, 1992

ENGLISH EXAMINATION MAY 08, 1993

VALID THROUGH



Michael Schuss
CHAIRMAN, BOARD OF TRUSTEES
Margaret Wilson
PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED SEPTEMBER 25, 1993

Hina
 NPAPOK
 151665
 MN

Supplementary Questionnaire

Physicians are requested to provide the following additional information relating to their practice and education

If your practice includes more than the two areas of specialty or sub-specialty about which you have previously told us in your renewal application, please list them here. (If Board Certified, include only ABMS Boards or Sub-Boards) Please list your primary specialty first. Please use codes from the enclosed specialty codes list.

Specialty	Board Certified (Y/N)	Specialty Board or Sub-Specialty Certificate
IM	no	
OBG	no	

Please list below your post-graduate medical training, including the beginning and ending dates for each, as well as a description of the training or appointment. (i.e. Internship, Residency, Fellowship, etc.) Please include the full month, day, and year for the beginning and ending of each. (No CVs, please.)

Training Site/Location	Start	End	Description of Training
Moscow City Hospital, Moscow, Russia	9/1/76	8/31/77	Internship, Intern. Med.
Moscow City Hospital, Moscow, Russia	9/1/77	8/31/79	Fellowship, Intern. Med.
Moscow Maternity Hospital, Moscow, Russia	9/1/85	8/31/87	Fellowship OBG
Salem Hospital, Salem, MA, USA	7/1/89	6/30/95	Internship Int. Med. / Primary Care
Salem Hospital, Salem, MA, USA	7/1/95	6/30/97	Residency Int. Med. / Primary Care

Massachusetts Physician Profiles

As many of you are aware, in 1996, the Legislature passed, and the Governor signed, a bill requiring the Board to provide a written profile of Massachusetts physicians to consumers upon request. A profile of each doctor is maintained by the Board for this purpose. When your application for renewal has been approved by the Board, a copy of your profile will be mailed to you, and you will be given an opportunity to correct any factual errors which it may contain before it is made available to the public. When you receive your profile in the mail you will see a notation that it cannot be released to the public before a certain date. This "hold period" will enable you to respond to the Board to make any appropriate corrections or additions. Responses may be made by mail, fax, or phone call to the Physician Profiles office at the Board. Subsequent to this "release date," your profile will be available to the public.

Your application for renewal contains several addresses. Your profile will be mailed to the address which you indicate is your place of business. If you wish Profiles correspondence to be sent to a different address, please notify the Profiles office of your preferred address.

You may obtain a copy of your profile at any time from the Profiles office, (617) 727-3086. Changes, additions, or deletions may be made whenever needed during the year, FAX to (617) 357-8453.



Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Initial Limited License Application, Page 1 of 2

\$ 50.00 Fee Payable to The Commonwealth of Massachusetts

4-22-94
PF

94-0745-95

Important:

- . Read the accompanying instructions in their entirety before completing this form.
. Print legibly or type your answers.
. Answer all non-optional questions (front and back of form) completely--Even though the Board may have the information, it is not adequate to state that the Board already has the information.
. Sign the application at the bottom of page two.
. Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ___ 2) Graduate of Foreign Medical School [checked]
3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) NATAPOV, (FIRST:) IRINA, (M.I.):

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name?
If yes, please specify (and attach documentation): Irina Georgievna Leviten (maiden name)

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: n/a

2. a) Name & address of Massachusetts Training Hospital: n/a

2. b) Local residence address & telephone: Tel.#

3. Place of Birth:

4. Date of Birth (MO/DA/YR): 5. Sex: MALE ___ FEMALE [checked] 6. Social Security No. (Optional):

7. a) Name of Premedical school(s): High School #625, Moscow 7 b) Location: Moscow, Russia
City, State, Country

8. a) Medical School Name: Moscow Medical and Dental School 8 b) Location: (City, State, Country) Moscow, Russia
(See #3 under instructions)

8. c) Year Graduated: 1976 8. d) Degree: M.D. [checked] D.O. ___ Other (Specify) RUS O.D.

9. a) Previous post-graduate training: [checked] yes ___ no

b) Name of institution: Hospital #36 Teaching Hospital of Medical Institute
Address: Fortunatovskaya St, Moscow Russia

c) Name of Program: Internal Medicine Dates of training: Internship - 9.1.76 - 2.31.77
Fellowship - 9.1.77 - 8.31.79

Continue answer on additional page if necessary

10. If you have had any one of the following, please circle which one and attach an explanation to this form: a) Leave of absence from medical school
b) USMG more than four years of medical school education. c) FMG more than six years of medical education. Question 10 applies to me ___ Yes
[checked] No. I have attached an explanation, Yes ___ No [checked].

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

This certifies that IRINA NATAPOV has been appointed to the position of Intern [checked] Resident ___

Fellow ___ in Program INT MEDICINE at SALEM HOSPITAL beginning 7/1/94
(Program) (Institution)

Anticipated completion Date of training 6/30/95 14

This program is accredited by the ACGME: Yes ___ No [checked]

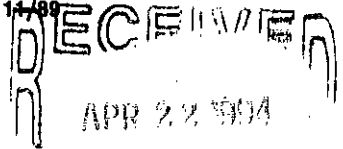
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___

Designated Official's Signature: Herbert L. Cooper MD

Type or Print Name and Title: HERBERT L. COOPER MD Chief of Medicine

(Applicant See reverse side - You must complete Section C)

FORM 14-89



MASS REGISTRATION BOARD

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now licensed to practice (Abbreviate): NY

12. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate): NY

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes No I have attached an explanation: Yes No See C.V. under Employment History.

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes No If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes No Program Director's Certification has been requested: Yes No

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

Yes No

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

16. Have you been a defendant in any criminal proceeding other than a minor traffic offense:

17. Are any formal disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (International, national, state or local)?

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

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?

21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of Medicine?

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?

23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?

24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?

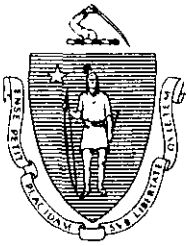
IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec.51A Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

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 limited licensure in Massachusetts.

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

Applicant's Signature: James Catalano Date: 04, 06, 99



Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

SECTION A: APPLICANT COMPLETE AND MAIL REQUEST TO ECFMG

ECFMG
3654 MARKET STREET
PHILADELPHIA, PA. 19104

DATE: 04/06/94

SECTION A: THE MASSACHUSETTS BOARD OF REGISTRATION IN
MEDICINE REQUESTS VERIFICATION OF MY ECFMG CERTIFICATION.

NAME Irina NATAPOV
(TYPED OR PRINTED)

ADDRESS _____
STREET ADDRESS

CITY, STATE AND ZIP CODE

PLACE OF BIRTH

DATE OF BIRTH

Moscow Medical and Dental School

NAME OF MEDICAL SCHOOL OF GRADUATION

Delegatskaya St., Moscow, Russia

ADDRESS OF MEDICAL SCHOOL

June 25, 1976

M.D.

DATE OF GRADUATION

DEGREE GRANTED

0-451-587-0

ECFMG NUMBER

SECTION B: This section is to be certified by the
Educational Council for Foreign Medical Graduates.

ECFMG CERTIFICATE # 0-451-587-0 EXPIRATION DATE 05/95

SIGNATURE Luis Santillon (SEAL OF ECFMG)

NAME: LUIS SANTILLON
VERIFICATION COORDINATOR
TYPED OR PRINTED

APR 22 1994
DATE

BOARD OF REGISTRATION
IN MEDICINE



Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

✓ Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No. Status Fee Date 96-0745-97

Table with columns for M.R., Pr., Bk., Ch., D.E., F. and rows for dates.

Important:

- Read the accompanying instructions in their entirety before completing this form.
Print legibly or type your answers.
Answer all non-optional questions (front and back of form) completely...

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

- 1. Name (LAST:) NATAPOV (FIRST:) IRINA (M.I.):
2. Mailing Address:
3. Name & Address of Training Hospital: SALEM HOSPITAL, 81 HIGHLAND AVE, SALEM MA 01970
4. Medical School Name: MOSCOW MEDICAL SCHOOL AND DENTAL SCHOOL
5. Current Limited License Number: 95-0745-96

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes X No

Type or Print Name and Title Wayne M. Trebbin, M.D., Program Director

Signature of Program Director [Handwritten Signature]

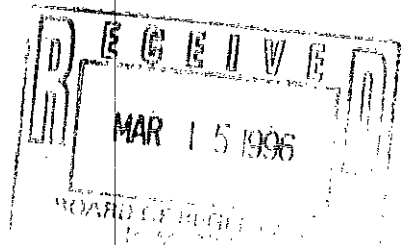
SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Irina Natapov has been appointed to the position of Intern Resident X
Fellow in Program Internal Medicine at Salem Hospital beginning 6/24/96 and
Anticipated completion date of training (Program) 6/30/97 (Institution)

This program is accredited by the ACGME: Yes X No
If no, we have an ACGME approved training program in the applicant's specialty: Yes No

Designated Official's Signature: [Handwritten Signature]
Type or Print Name and Title: Wayne M. Trebbin, M.D. Date: 2/14/96
Program Director

(Applicant See reverse side - You must complete Section C)



SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice: (Abbreviate): none

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

Yes No

- 15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: JAMES WATSON Date: 01/31/96

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Irina Nafapov Day time phone #: _____

MAILING ADDRESS:

Marblehead, MA 01945

Business Address:

Keep # 889
 Salem Hospital
 81 Highland Ave
 Salem MA 01970

Address valid until: 1/97

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

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

YES NO

1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?
6. Have you ever failed a foreign licensing or certification examination?
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?
12. Have you ever, for any reason, lost American Specialty Board Certification?
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?
20. Have you ever been enrolled in a residency training program(s) that you did not complete?

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

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

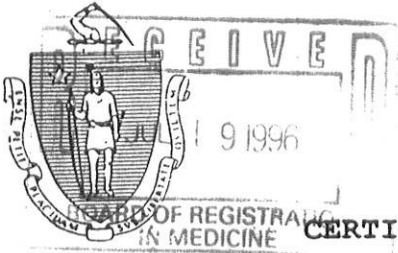
IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.


I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: Irina NafapovDATE: 07.16.96



CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

ATTENTION APPLICANT: This certificata must be signed by a physician legally authorized to practice medicine in the United States. This statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts. **PLEASE HAVE CERTIFYING PHYSICIAN RETURN DIRECTLY TO THE BOARD.**

PHOTOGRAPH	CERTIFICATE OF MORAL & PROFESSIONAL CHARACTER
	<p>This certifies that I have been personally acquainted with <u>Irina NATAPOV</u> (NAME)</p> <p>(ADDRESS)</p> <p>for <u>20</u> years; that I believe <u>her</u> to be of good moral & professional character, and in every respect worthy of confidence. I recommend <u>her</u> to the Massachusetts Board of Registration in Medicine.</p> <p><u>P. Tsyvin</u> M.D. Signature of certifying physician</p> <p><u>TSYVIN POLINA</u> NAME TYPED OR PRINTED</p> <p>ADDRESS of certifying physician</p> <p>License # <u>80043</u> State <u>MA</u></p> <p>DATE: <u>07/12/96</u></p>
<p><u>Irina Natapov</u> Signature of Applicant</p> <p>I certify that the photograph above is a genuine likeness of the maker of the signature above.</p> <p><u>Laura Banks</u> Signature of Notary</p> <p><u>9/28/01</u> (Expiration Date of Commission)</p>	

CERTIFYING PHYSICIAN: PLEASE RETURN DIRECTLY TO: THE BOARD OF REGISTRATION IN MEDICINE, 10 WEST ST., BOSTON, MA 02111



COMPLETED

Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.: 151665 Renewal Date: 04/26/2001

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

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

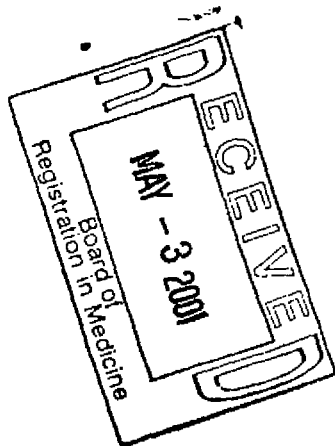
2. Other Name(s), if any, under which you were licensed:

Please make corrections (type or print)

Other Name(s): _____
Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (____) _____
Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (____) _____

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

3. A) Mailing/Business Address:
 IRINA NATAPOV
 34 STATE STREET
 LYNN, MA 01901



B) Home Address:

Home Phone:

Business Phone:

(781) 581-6181

4. a) Date of Birth: _____ b) Sex: F
 c) SS#: _____
 5. a) Name of Medical School: _____
 b) Year Graduated: 1976 c) Degree: M.D.
 Moscow Med Stomatologesij Inst, Moscow, Russia
 6. Specialty Code(s) (See Table 1)
 Code(s) Hours per Week in Mass.
 IM 0 Internal Medicine
 ORG 0 Obstetrics and Gynecology

7. Current American Board of Medical Specialties Certification (See Table 2)
 Code: _____ Code: _____
 8. Drug License Numbers, if any:
 a) Federal (DEA): _____
 b) Massachusetts: _____
 9. a) Other states where you are now licensed to practice (Abbr.)

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

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

Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
 Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
 If 999, print name(s): _____

COMPLETED

PRINT YOUR LAST NAME: _____

LICENSE NUMBER: _____

157666

My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit

Name of Insurer: Promutual Group Alternatively, indicate as follows:

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

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

Please explain exemption: _____
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) Yes No

13. A. What is your principal work setting? (See Table 4) 10 15
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 12-40 hrs/wk b) inpatient care 15-20 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

- 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
- 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
- 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?
- 17. Have you been charged with any criminal offense, other than a minor traffic violation?
- 18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
- 19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?
- 20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
- 21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
- 22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? Yes No
 CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) CME exemption

YES	NO

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.
Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

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

Signature: *Irma Madala*
Irma Madala

Date: 3, 6, 01
4/30/01

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

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

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



Physician Registration Renewal Application

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

- Remit \$250.00 for renewal fee.
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

1. Current Status: Active

Registration No.: 151665

Renewal Date: 04/26/2001

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

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

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

Please make corrections (type or print)

Other Name(s): _____
Mailing Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____
Business Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____ Business Telephone: (____) _____
Home Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____ Home Telephone: (____) _____
PLEASE NOTE: No P.O. Box addresses for home or business addresses.

3. A) Mailing/Business Address:

IRINA NATAPOV
 34 STATE STREET
 LYNN, MA 01901

B) Home Address:

Home Phone:

Business Phone:

(781) 581-6181

4. a) Date of Birth:

b) Sex: F

c) SS#:

5. a) Name of Medical School:

b) Moscow Med Stomatologesij Inst, Moscow, Russia
 Year Graduated: 1976 c) Degree: M.D.

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

Code(s) Hours per Week in Mass.

IM 0 Internal Medicine
 OBG 0 Obstetrics and Gynecology

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

8. Drug License Numbers, if any:

- a) Federal (DEA):
 b) Massachusetts:

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

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

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

Facility Code: 538 / (AP) 25 % Facility Code: / (AP) % Facility Code: / (AP) %
 Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
 If 999, print name(s): Union Hospital (PSMC)

CONFIDENTIAL MEDICAL INFORMATION

01501010

PART B

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS:

YES NO

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

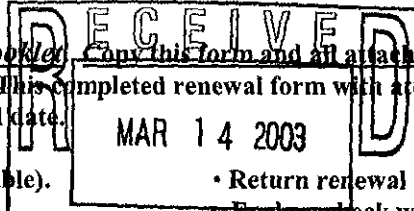
Signature: *Jirna Nadapo*
Jirna Nadapo

Date: 3, 6, 01
4/30/07

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING



Physician Registration Renewal Application



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

- Remit \$400.00 for renewal fee (non-refundable).
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

1. Current Status: Active Registration No.: 151665 Renewal Date: 04/26/2003

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

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

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

Please make corrections (print)

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

A) Mailing/Business Address:
 3. IRINA NATAPOV
 34 STATE STREET
 Lynn, MA 01901

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

B) Home Address:

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

Home Phone:

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

Business Phone:

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

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

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

5. a) Name of Medical School:
 Moscow Med Stomatologicesij Inst, Moscow, Russia
 b) Year Graduated: _____ c) Degree: 1976

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

6. Specialty Code(s) (See Table 1)
 Code(s) Hours per Week in Mass.

9. a) Other states where you are now licensed to practice (Abbr.) _____
 b) States where you were previously licensed (Abbr.) _____

IM 0 Internal Medicine
 OBG 0 Obstetrics and Gynecology

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

Facility Code: 538 (AP) 25 % Facility Code: _____ (AP) _____ % Facility Code: _____ (AP) _____ %
 Facility Code: _____ (AP) _____ % Facility Code: _____ (AP) _____ % Facility Code: _____ (AP) _____ %
 If 999, print name(s): Union Hospital (N.S.M.C.)

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the period since you signed your last renewal application. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS:

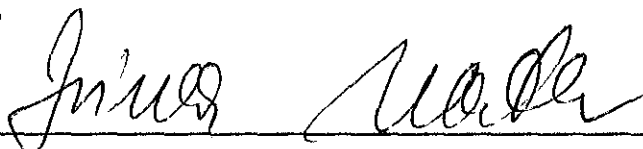
YES NO

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: 

Date: 03 / 07 / 03

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Massachusetts Physician Renewal Application

Physician Name: **IRINA NATAPOV**

License No.: **151665**

PART A

1) Current Status: Active

Renewal Due Date: 03/29/2005

Birth Date:

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

- Active
 Retiring
 Inactive
 Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

34 STATE STREET
Lynn, MA 01901

Check here to change this address

2b) HOME ADDRESS

Phone:

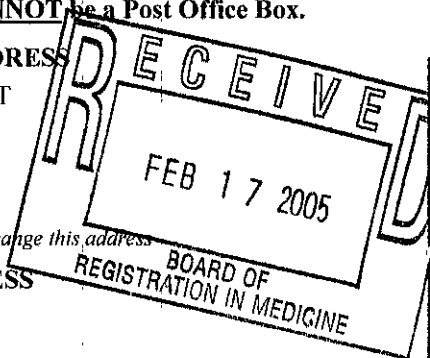
Check here to change this address

2c) BUSINESS ADDRESS

34 STATE STREET
Lynn, MA 01901

Phone: (781)581-6181 Ext. 889

Check here to change this address



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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 781-599-3229

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Internal Medicine	<input checked="" type="checkbox"/>	
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
	<input type="checkbox"/> <input type="checkbox"/>	Internal Medicine	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: **IRINA NATAPOV**

License No.: **151665**

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers, if any:</p> <p>a) Massachusetts:</p> <p>b) Federal (DEA):</p> <p>c) Federal (DEA) XS:</p>	<p style="text-align: center;"><i>Please make corrections as necessary</i></p> <p>8a) Other states where you are <u>now</u> licensed to practice (Abbr.)</p> <p style="text-align: center;">_____</p> <p>8b) States where you were <u>previously</u> licensed (Abbr.)</p> <p style="text-align: center;">_____</p>
--	--

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

Principal Work Setting: Private Office Change to: _____

Please enter principal work setting hours per week here: 32⁰

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

No Affiliations

Health Care Facility <i>(See Renewal Instructions, page 4.)</i>	Delete?	Staff Category		# Hours per Week
		Current	Change	
Union Hospital	<input type="checkbox"/>	<i>active</i>		<i>10-15</i>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: 15-20 hrs/wk

b) outpatient care 32 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: Promutual Insurance Change to: _____

Policy dates: From 01/01/2005 To 12/31/2005
(required)

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

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

Check one:

Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: **IRINA NATAPOV**

License No.: **151665**

13) Do you perform any surgery in your office? (See Renewal Instructions, page 5.)

If Yes, please complete Form PCA-O "Office Based Surgery"

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: IRINA NATAPOV

License No.: 151665

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application.

(See Renewal Instructions, page 9.)

YES NO

- 23) Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (see Renewal Instructions, page 9.)

- 24) Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

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

Signature:

Irina Natapov

Date:

02, 04, 05

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

Massachusetts Physician Renewal Application

Physician Name: IRINA NATAPOV

License No.: 151665

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

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

Signature: _____

Irina Nataпов

Date: _____

02, 07, 05

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

City of Lynn, Massachusetts

OFFICE OF THE CLERK



Mary F. Audley
City Clerk

October 10, 2006

Commonwealth of Massachusetts
Board of Registration in Medicine
C/O Office of Consumer Affairs
and Business Regulations
560 Harrison Avenue, Suite G4
Boston, Massachusetts 02118

Re: City of Lynn Physician Registration
Irina Natapov, MD License # 151665

Dear Board of Registration,

In accordance with the provision of Section 8, Chapter 112 of the General Laws, I hereby certify the above physician has exhibited his certificate and certificate number issued under authority of the laws of the Commonwealth of Massachusetts and has paid the required fee.

If you have any questions regarding the enclosed registered physician list, please call my office and speak with Assistant City Clerk Janet Rowe at 781-586-6726. Thank you.

Very Truly Yours,

Mary F. Audley
City Clerk

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 **will be required to obtain an NPI by May 23, 2007.**

In order for your license to be renewed you must take one of the following actions:

- Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPES web site at www.NPES.cms.hhs.gov.
- Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
- Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
- Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
- Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- My current NPI is: 16199799018
- I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to enclosed Taxonomy Code List). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

207R00000X

Internal Medicine

Provider Taxonomy:

Provider Taxonomy:

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): _____

Country of Birth (if outside the US): _____

Gender: Male

Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: I authorize I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.

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

Signature: _____

Irina Natapov

Date: _____

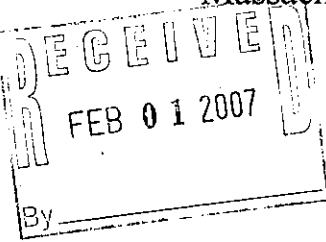
01/29/2007

02/02/07 88 24



Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org



Dr. Irina Natapov
34 State Street
Lynn, MA 01901

01/24/2007

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

02/22/07 51 585

PART A

1) **Current Status:** Active

Renewal Due Date: 03/29/2007

Birth Date:

If you want to change your current status, please check one of the following boxes to indicate your new status:

Check only one: (See Renewal Instructions, page 3.)

- Active
 Retiring
 Inactive
 Do not wish to renew

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

2a) MAILING ADDRESS

34 State Street
Lynn, MA 01901

RECEIVED

FEB 21 2007

Check here to change this address

2b) HOME ADDRESS

Phone:

Check here to change this address

2c) BUSINESS ADDRESS

34 STATE STREET
Lynn, MA 01901

Phone: (781)581-6181 Ext. 889

Check here to change this address

Please make corrections (print)

Mailing Address: 24 State Street
 City/Town: Lynn State: MA
 Zip: 01901 Country: Essex

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

Home address cannot be a Post Office Box

Business Address: 24 State Street
 City/Town: Lynn State: MA
 Zip: 01901 Country: Essex
 Business Telephone: (781) 581-6181

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

3) **E-mail Address:** _____

4) **Fax Number:** (781) 599-3229

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Internal Medicine	<input checked="" type="checkbox"/>	
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Internal Medicine	ABMS	Internal Medicine	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

02/22/07 91 898

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers Corrections:</p> <p>a) Massachusetts: _____</p> <p>b) Federal (DEA): _____</p> <p>c) Federal (DEA) XS: _____</p>	<p style="text-align: center;"><i>Please make corrections as necessary</i></p> <p>8) Other states where you are <u>now</u> licensed to practice</p> <p>_____</p> <p>9) States where you were <u>previously</u> licensed</p> <p>_____</p>
--	--

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
Union Hospital	Lynn	MA	<input type="checkbox"/>
TRC MH office	Swampscott	MA	<input type="checkbox"/>
	Lynn	MA	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: _____ hrs/wk

b) outpatient care 32 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: Promutual Insurance Change to: _____

Policy dates: From 01/01/2007 To 01/01/2008

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

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

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

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

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

02/22/07 91 535

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

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

	YES	NO
14) CLAIMS MADE a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above). b) PENDING: Are there any unresolved malpractice claims against you today , i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		
22) CME CERTIFICATION: a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No A CME waiver request form must be submitted at least 30 days prior to your license expiration date. c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.) CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training		

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

02/22/07 91 937

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application. (See Renewal Instructions, page 10.)

YES NO

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? If your answer is "Yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (See Renewal Instructions, page 10.)

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

02/22/07 91

0309

PART C

Check One:

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 11.*)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

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

Signature: _____



Date: _____

02, 13, 2007

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



Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite G-4

Boston, MA 02118

617-654-9810

www.massmedboard.org

02/22/07 91 555

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin C. Crane MD".

Martin C. Crane, M.D.

Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

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 will be required to obtain an NPI by May 23, 2007.

In order for your license to be renewed you must take one of the following actions:

- Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.
- Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
- Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
- Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
- Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- My current NPI is:
- I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	_____
Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	_____
Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	_____

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: - -

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: Male Female

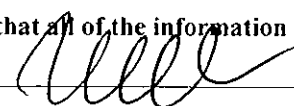
Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: I authorize I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.

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

Signature:  Date: 02, 13, 2007

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

001/04/09 09:55:00

PART A

1) Current Status: Active

Renewal Due Date: 03/29/2009

Birth Date:

If you want to change your current status, please check one of the following boxes to indicate your new status:

Check only one: (See Renewal Instructions, page 3.)

- Active
 Retiring
 Inactive
 Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

24 State Street
Lynn, MA 01901

Check here to change this address

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

2b) HOME ADDRESS

APR 5 0 2009
 Board of Registration
 in Medicine

Phone:

Check here to change this address

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

24 State Street
Lynn, MA 01901

Phone: (781)581-6181 Ext. 889

Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: (781) 599-3229

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Internal Medicine	<input type="checkbox"/>	
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Internal Medicine	ABMS	Internal Medicine	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

03/21/09 93
7

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

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
Union Hospital	Lynn	MA	<input type="checkbox"/>
office	Lynn	MA	<input type="checkbox"/>
See MA	Dorchester	MA	<input type="checkbox"/>
Life Care Ctr MA	Lynn	MA	<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: 30 hrs/wk
b) outpatient care 32 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: Promutual Insurance Change to: _____

Policy dates: From 01/01/09 To 01/01/10

Type of Policy: Claims made with tail coverage Occurrence Policy
(Enclose a copy of the certificate of insurance or the face sheet)

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

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

Check one: Not involved with direct or indirect patient care in Massachusetts
 A Government Employee under Federal Tort Claims Act (FTCA)
 Otherwise exempt *(Please explain):* _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

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

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

08/24/05 09:50:45Z

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

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

YES NO

<p>14) CLAIMS MADE</p> <p>a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above).</p> <p>b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?</p>	
<p>15) CLAIMS CLOSED</p> <p>Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?</p>	
<p>16) OTHER CIVIL LAWSUITS</p> <p>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.</p> <p>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?</p> <p>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</p>	
<p>17) CRIMINAL CHARGES</p> <p>a) Have you been charged with any criminal offense during this time period?</p> <p>b) Have any criminal offenses/charges against you been resolved during this time period?</p> <p>c) Are there any criminal charges pending against you today?</p> <p>d) Are any Applications for Issuance of Process pending against you?</p>	
<p>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</p> <p>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</p> <p>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?</p> <p>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?</p> <p>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?</p>	
<p>19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?</p>	
<p>20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?</p>	
<p>21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?</p>	

<p>22) CME CERTIFICATION:</p> <p>a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A CME waiver request form must be submitted at least 30 days prior to your license expiration date.</p> <p>c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)</p> <p>CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training</p>

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

08/21/09 09 10

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application. (See Renewal Instructions, page 10.)

YES NO

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? If your answer is "Yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (See Renewal Instructions, page 10.)

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

03/05/2009 15:56

PART C

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

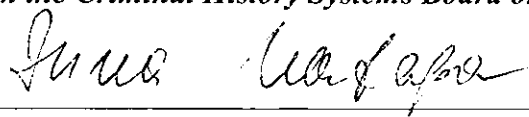
Check One:

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 11.*)

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

Signature: _____



Date: 03, 05, 2009

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

FORM PCA-O (OFFICE BASED SURGERY)

If you answered "Yes" to Question #13 on your Renewal Application you must complete this PCA-O form, and include it with your renewal application. Please refer to the Massachusetts Medical Society (MMS) Office Based Surgery Guidelines and Instruction Booklet when completing this form. The Office Based Surgery Guidelines have been endorsed by the Board and are available at the Board's website at www.massmedboard.org.

Please be advised that the Board will use the information on this form to evaluate office based surgery standards across the state of Massachusetts only. The Licensing staff will forward this form directly to the Patient Care Assessment (PCA) office where your license number and name will remain confidential and will not be used for disciplinary purposes.

1. Please indicate your Office Facility Classification under the MMS Office Based Surgery Guidelines:

- Level I Office Level II Office Level III Office

2. If you indicate that you are a Level II or Level III Office please complete the following:

a) Provide the name of the Organization that accredited your practice:

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

c) Do you have the Training required and defined in the MMS Office Based Surgery Guidelines for the Level of office surgery that you are performing (Level II or Level III)? Yes No

d) Do you have written policies and procedures for Emergency Care and Transfer; Medical Record and Anesthesia Care documentation; Infection Control and Patients' Bill of Rights as required and defined in the MMS Office Based Surgery Guidelines? Yes No

e) Do you have written policies and procedures for compliance with applicable federal and state laws and regulations, and reporting adverse incidents to the Massachusetts Board of Registration in Medicine, as required and defined in the MMS Office Based Surgery Guidelines? Yes No

f) Do you have a written Performance Improvement Program as required and defined in the MMS Office Based Surgery Guidelines? Yes No

3. If you responded "No" to any of the questions noted above, please briefly explain your response.

Signed: _____ **Date:** ___/___/___

See frequently asked questions and description of Levels I, II and III on the attached instruction sheet.

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

09/21/09 83

FREQUENTLY ASKED QUESTIONS REGARDING OFFICE BASED SURGERY- FORM PCA-O

Question #1:

“If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?”

Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form in its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org

Question #2:

“I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?”

The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org

Question #3:

“If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?”

You only have to fill out the form if you perform office-based procedures in Massachusetts.

Question #4:

“I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?”

No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.

Question #5

“I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?”

You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

Beerun T

PART A

1) Current Status: Active

Renewal Due Date: 03/29/2009

Birth Date:

If you want to change your current status, please check one of the following boxes to indicate your new status:

Check only one: (See Renewal Instructions, page 3.)

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

24 State Street
Lynn, MA 01901

Check here to change this address

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

2b) HOME ADDRESS

MAR 5 0 2009
Board of Registration
in Medicine

Phone: _____

Check here to change this address

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

24 State Street
Lynn, MA 01901

MAR 5 0 2009
Board of Registration
in Medicine

Phone: (781)581-6181 Ext. 889

Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: (781) 599-3229

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Internal Medicine	<input type="checkbox"/>	
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Internal Medicine	ABMS	Internal Medicine	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

009101 090 533 377

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers</p> <p>a) Massachusetts: _____</p> <p>b) Federal (DEA): _____</p> <p>c) Federal (DEA) XS: _____</p>	<p><i>Please make corrections as necessary</i></p> <p>8) Other states where you are <u>now</u> licensed to practice</p> <p>_____</p> <p>9) States where you were <u>previously</u> licensed</p> <p>_____</p>
---	--

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
Union Hospital	Lynn	MA	<input type="checkbox"/>
office	Lynn	MA	<input type="checkbox"/>
See MA	Dorchester	MA	<input type="checkbox"/>
Life Care Ctr MA	Lynn	MA	<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: 30 hrs/wk

b) outpatient care 32 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: Promutual Insurance Change to: _____

Policy dates: From 01/01/09 To 01/01/10

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

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

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

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

Massachusetts Physician Renewal Application

Physician Name: **Irina Natapov, M.D.**

License No.: **151665**

09/21/2019 09:53:33

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

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

YES NO

<p>14) CLAIMS MADE</p> <p>a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above).</p> <p>b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?</p>	
<p>15) CLAIMS CLOSED</p> <p>Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?</p>	
<p>16) OTHER CIVIL LAWSUITS</p> <p>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.</p> <p>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?</p> <p>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</p>	
<p>17) CRIMINAL CHARGES</p> <p>a) Have you been charged with any criminal offense during this time period?</p> <p>b) Have any criminal offenses/charges against you been resolved during this time period?</p> <p>c) Are there any criminal charges pending against you today?</p> <p>d) Are any Applications for Issuance of Process pending against you?</p>	
<p>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</p> <p>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</p> <p>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?</p> <p>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?</p> <p>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?</p>	
<p>19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?</p>	
<p>20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?</p>	
<p>21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?</p>	

<p>22) CME CERTIFICATION:</p> <p>a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A CME waiver request form must be submitted at least 30 days prior to your license expiration date.</p> <p>c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)</p> <p style="text-align: center;">CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training</p>

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application. (See Renewal Instructions, page 10.)

YES NO

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? If your answer is "Yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (See Renewal Instructions, page 10.)

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.

01/11/2011 10:45:40 AM

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

03-12-09 09:55:44

PART C

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Check One:

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 11.*)

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

Signature: _____

Irina Natapov

Date: 03/05/2009

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

FORM PCA-O (OFFICE BASED SURGERY)

If you answered "Yes" to Question #13 on your Renewal Application you must complete this PCA-O form, and include it with your renewal application. Please refer to the Massachusetts Medical Society (MMS) Office Based Surgery Guidelines and Instruction Booklet when completing this form. The Office Based Surgery Guidelines have been endorsed by the Board and are available at the Board's website at www.massmedboard.org.

Please be advised that the Board will use the information on this form to evaluate office based surgery standards across the state of Massachusetts only. The Licensing staff will forward this form directly to the Patient Care Assessment (PCA) office where your license number and name will remain confidential and will not be used for disciplinary purposes.

10/15/13
10/15/13
10/15/13
10/15/13
42

1. Please indicate your Office Facility Classification under the MMS Office Based Surgery Guidelines:

- Level I Office Level II Office Level III Office

2. If you indicate that you are a Level II or Level III Office please complete the following:

a) Provide the name of the Organization that accredited your practice:

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

c) Do you have the Training required and defined in the MMS Office Based Surgery Guidelines for the Level of office surgery that you are performing (Level II or Level III)? Yes No

d) Do you have written policies and procedures for Emergency Care and Transfer; Medical Record and Anesthesia Care documentation; Infection Control and Patients' Bill of Rights as required and defined in the MMS Office Based Surgery Guidelines? Yes No

e) Do you have written policies and procedures for compliance with applicable federal and state laws and regulations, and reporting adverse incidents to the Massachusetts Board of Registration in Medicine, as required and defined in the MMS Office Based Surgery Guidelines? Yes No

f) Do you have a written Performance Improvement Program as required and defined in the MMS Office Based Surgery Guidelines? Yes No

3. If you responded "No" to any of the questions noted above, please briefly explain your response.

Signed: _____ Date: ____/____/____

See frequently asked questions and description of Levels I, II and III on the attached instruction sheet.

Massachusetts Physician Renewal Application

Physician Name: Irina Natapov, M.D.

License No.: 151665

FREQUENTLY ASKED QUESTIONS REGARDING OFFICE BASED SURGERY- FORM PCA-O

Question #1:

“If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?”

Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form in its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org

Question #2:

“I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?”

The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org

Question #3:

“If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?”

You only have to fill out the form if you perform office-based procedures in Massachusetts.

Question #4:

“I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?”

No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.

Question #5

“I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?”

You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.



Commonwealth of Massachusetts
Board of Registration in Medicine

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

April 01, 2009

Irina Natapov M.D.
24 State Street
Lynn, MA 01901

Dear Doctor Natapov:

RE: Incomplete Renewal Application

License Expiration Date: 04/26/2009

Your renewal application is incomplete and is being returned to you to provide the missing documentation required to complete the renewal process. The missing information or additional documentation is listed on the attached missing information list.

Your license renewal date is the same as your birth date. Please be advised that if you do not renew your license before your birth date, you cannot practice medicine after 11:59 p.m. on your birthday and your license will lapse.

Revival of a lapsed license requires completing a lapsed license application, including a check for the lapsed license fee of \$600.00 and submitting a National Practitioner Data Bank Profile and an AMA Profile. It may take up to three (3) weeks for the National Practitioner Data Bank and AMA to process profile requests.

The Board is required to notify all health care facilities at which you have privileges and your liability insurance carrier if your license is not renewed before the renewal date.

Please enclose your completed renewal application and any required attachments in the enclosed preprinted envelope addressed to the Board of Registration in Medicine.

Sincerely,

Rose M. Foss, Director
Licensing Division

CERTIFIED MAIL, RETURN RECEIPT REQUESTED



06/09/09 01 79

Mass.

• online services • agencies • elected officials • help

Back | Home | How to Read a Profile

151665



Massachusetts Board of Registration in Medicine Physician Profile

Irina Natapov, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status: Active
License Issue Date: 9/25/1996
Accepting New Patients: Yes
Accepts Medicaid: Yes
Primary Work Setting: Private Office
Business Address: 24 State Street
 Lynn, MA 01901
Phone: (781) 581-6181 Ext.889
Translation Services Available: None Reported
Insurance Plans Accepted: Blue Cross Blue Shield
 Cigna
 Harvard Pilgrim Health Care
 Medicaid
 Medicare
 Tufts
 United HealthCare
Hospital Affiliations: Union Hospital

II. Education & Training

Medical School: Moscow Med Stomatologicesij Inst, Moscow, Russia
Graduation Date: 1976
Post Graduate Training: Moscow City Hospital #36 - Intern/Fellow-Int Med (7/1/1976-6/30/1979)
 Moscow Maternity Hospital #25 - Fellowship (7/1/1985-6/30/1987)
 Salem Hospital - Intern/Resid-Int Med, pri Care (7/1/1994-6/30/1996)

III. Specialty

Area of Specialty: Internal Medicine
Obstetrics and Gynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

none reported

06/08/08 01 77

<u>Board Name</u>	<u>General Certification</u>	<u>Subspecialty</u>
Internal Medicine	Internal Medicine	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Natapov has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

08/09/09 01
73

- A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Natapov has had no criminal convictions in the past ten years.

- B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Natapov has no record of hospital discipline in the past ten years.

- C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Natapov has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
 Phone 781-876-8230
 Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
 Physician Profile Search
 Direct questions and comments about these results to
 Massachusetts Board of Registration in Medicine
 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
 Phone 781-876-8200
 For direct response please use Email

Please read the Board of Registration in Medicine [Disclaimer](#)



©2008 Commonwealth of Massachusetts

[privacy policy](#) [site map](#) [terms of use](#)

To: Board of Registration in Medicine of Massachusetts
Fax: 781-876-8382

From: Irina Natapov, M.D.
Ph: 781-581-6181
Fax: 781-599-3229
E-mail:

Re: Physicien profile.

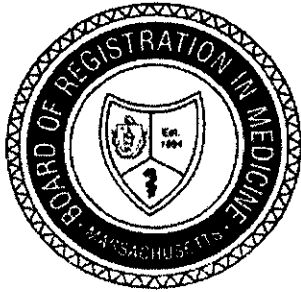
05/29/2009

To whom it may concern,

Information in my physician profile is not correct.
In part IV Board Certification was given wrong information.
Would you please to change it to "not report".

Thank you.
Irina Natapov, M.D.

05/29/09 01 79



BOARD OF REGISTRATION IN MEDICINE

200 Harvard Mill Square, Suite 330

Wakefield, Massachusetts 01880

(781) 876-8200

<http://www.massmedboard.org>

MAR 26 2009

Board of Registration
in Medicine

08/17/09 52

3

COMPLAINT INTAKE FORM FOR PHYSICIANS

The Board of Registration in Medicine licenses and regulates physicians and acupuncturists. Type or print legibly in ink. Do not write in the margins.

To facilitate the processing of this complaint, ensure that all documents are legible. If you are submitting copies of relevant documents to support your complaint, they should be in paper form only. You may include photographs, which cannot be returned. Do not send objects, tapes, videos, CDs or X-rays.

Additional information or materials attached

Yes

No

COMPLAINANT INFORMATION:

Your relationship to the patient (i.e. parent, self or spouse) <u>daughter</u>			
Gender:	<input checked="" type="checkbox"/> Female	<input type="checkbox"/> Male	Date of Birth _____
<u>Sokolov</u>	<u>Irene</u>		
Last Name	First Name	Middle Initial	
Address <u>o</u>		Daytime Phone _____	
City _____	State _____	Zip Code _____	Alternate Phone _____

PATIENT INFORMATION:

Same as above:

Yes

No

Gender:	<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Male	Date of Birth _____
_____	_____	_____	_____
Last Name	First Name	Middle Initial	
Address _____		Daytime Phone _____	
City _____	State _____	Zip Code _____	Alternate Phone _____

PHYSICIAN INFORMATION: (Use separate form for each licensed physician)

<u>Natapov</u>	<u>Irina</u>		
Last Name	First Name	Middle Initial	
<u>24 State Street</u>		<u>781-581-6181</u>	
Address		Business Phone	
<u>Lynn</u>	<u>MA</u>	<u>01901</u>	<u>MD Family Doctor</u>
City	State	Zip Code	Specialty <u>Internal medicine</u>

MEDICAL TREATMENT INFORMATION:

How long has the patient been under this physician's care? 2001-2009

If the patient is deceased, provide the date of death. _____

Location of treatment: Office Practice Clinic Hospital Nursing Home Other _____

Treatment site (list if different than the address provided on page one in the physician information section)

<u>Private office</u>			
Name of treatment facility			
<u>24 State Street</u>		<u>781-581-6181 ext 889</u>	
Address		Daytime Phone	
<u>Lynn</u>	<u>MA</u>	<u>01901</u>	_____
City	State	Zip Code	Alternate Phone

ADDITIONAL HEALTHCARE PROVIDER INFORMATION:

Please list the names, addresses and types of other healthcare providers, i.e., physicians, dentists or chiropractors, who provided treatment that may relate to this complaint. (Use a separate sheet if necessary.)

Name <u>J. U.</u>			
Address _____			
_____		Daytime Phone _____	
City		State	
_____		Zip Code _____	
_____		Type of Provider <u>Cardiovascular Diseases</u>	

Name _____			
Address _____			
_____		Daytime Phone _____	
City		State	
_____		Zip Code _____	
_____		Type of Provider _____	

ACKNOWLEDGEMENT

By signing and submitting this form, I acknowledge that the Board of Registration in Medicine may (1) refer my complaint to other appropriate law enforcement or regulatory authorities; and (2) may obtain medical records and other information relating to this complaint. In addition, I acknowledge that a copy of my complaint and all attachments may be forwarded to the physician. I further acknowledge that, if I am not the patient, the Board will not share the patient's confidential medical information with me without legal proof that I am authorized to receive such information. I attest that the information provided by me is true, correct and complete to the best of my knowledge.

Complainant signature _____ Date 3/23/09

Printed name of Complainant _____

COMPLAINT DESCRIPTION:

Dates of events that form the basis for this complaint: 2001-2009

Briefly describe your complaint

On behalf of my father, I respectfully request that you review the information being provided. _____ has been under the care of Dr Irina Natapov for approximately nine years.

This past January, _____ has been diagnosed with metastasized pappillary renal cell carcinoma. The oncologists cannot begin treatment based on test result that confirm a low platelet count, The medical records reflect this problem has existed since 2001 and the patient was not informed.

The documentation that has now been made available indicates that in 2001, the platelet count was 115. By 2006 it had dropped to 77. _____ is considered to be a thrombocytopenic patient. Potentially this category is at risk for bleeding and immune disorders. During this time frame with the results that I have provided there was never any suggestion of follow-ups or referrals to specialists such as hemalogists and/or oncologists. Our family brings this situation to your attention so that perhaps others will not be subjected to a practice of incompetence, irresponsibility and negligence by Dr. Irina Natapov.

I look forward to your response

(Use a separate sheet if necessary.)

Regards. -

3/23/09

Complainant signature

Date

Mail this form to:

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

March 18, 2009

To Whom It May Concern:

On behalf of my father, information being provided. for approximately nine years.

I respectfully request that you review the has been under the care of Dr. Irina Natapov

This past January, has been diagnosed with metastasized papillary renal cell carcinoma. The oncologists cannot begin treatment based on test results that confirm a low platelet count. The medical records reflect this problem has existed since 2001 and the patient was not informed.

The documentation that has now been made available indicates that in 2001, the platelet count was 115. By 2006 it had dropped to 77.

is considered to be a thrombocytopenic patient. Potentially this category is at risk for bleeding and immune disorders. During this time frame with the results that I have provided there was never any suggestion of follow-ups or referrals to specialists such as hematologists and/or oncologists.

Our family brings this situation to your attention so that perhaps others will not be subjected to a practice of incompetence, irresponsibility and negligence by Dr. Irina Natapov.

We look forward to your response.

Regards,

(Daughter)



Commonwealth of Massachusetts
Board of Registration in Medicine

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

08/17/09 S2

12

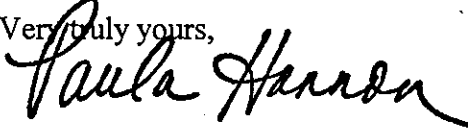
April 13, 2009

Re: Irina Natapov, M.D.
Docket Number: 09-172

Dear Ms. :

Your complaint regarding the physician named above has been received. The physician involved has been asked to respond in writing to your complaint. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to me at the address above.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/jec





Commonwealth of Massachusetts
Board of Registration in Medicine

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

July 23, 2009

Re: Irina Natapov, M.D.
Docket Number: 09-172

Dear Ms. :

The Complaint Committee of the Board of Registration in Medicine met on June 3, 2009 and considered information gathered regarding your complaint against the physician referenced above.

The Committee has decided to close the complaint. The Committee wants you to know that this complaint is now a permanent part of the physician's records at the Board.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/jec





Commonwealth of Massachusetts
Board of Registration in Medicine

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

April 13, 2009

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Irina Natapov, M.D.
24 State Street
Lynn, Massachusetts 01901

7006 3450 0003 0416 6087

Re: Irene Sokolov
Docket Number: 09-172

Dear Dr. Natapov:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed.

Please provide a written response, signed by you, to the issues raised in the enclosed material. As part of your response, you may include any materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee.

Your response must be sent to me, at the address above, within thirty days. This time frame commences on the date listed above. After your response is received, the case will be reviewed and a determination will be made about how to proceed. You will be notified of this decision.

Thank you for your attention to this request.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/jec
Enclosure

09/17/09 52

15



08/17/09 32
17



Seaport World Trade Center West
155 Seaport Boulevard
Boston, MA 02210-2600

617 832 1000 *main*
617 832 7000 *fax*

Fax

Date: May 11, 2009

To: Ms. Paula Hannon
Consumer Protection Coordinator Fax #: 781-876-8381 Confirm #:

Client Matter #: 29035-2
From: Colin Zick User #: 0563
Total Pages Sent (Including Cover Sheet): 2 Sender's #: 617 832 1275 Office: Boston

Message

Please see attached correspondence.

IMPORTANT -- PLEASE READ

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS INTENDED ONLY FOR THE PERSONAL AND CONFIDENTIAL USE OF THE DESIGNATED RECIPIENTS NAMED ABOVE. THIS MESSAGE MAY BE AN ATTORNEY-CLIENT COMMUNICATION AND AS SUCH IS PRIVILEGED AND CONFIDENTIAL. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR AN AGENT RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS DOCUMENT IN ERROR, AND THAT ANY REVIEW, DISSEMINATION, DISTRIBUTION OR COPYING OF THIS MESSAGE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US BY MAIL. THANK YOU.

IF THERE ARE ANY PROBLEMS WITH THIS TRANSMISSION PLEASE TELEPHONE THE SENDER.



Seaport World Trade Center West
155 Seaport Boulevard
Boston, MA 02210-2600

617 832 1000 main
617 832 7000 fax

Colin J. Zick
617 832 1275 direct
czick@foleyhoag.com

May 11, 2009

By Facsimile: (781) 876-8381

Ms. Paula Hannon
Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Re: Complaint by regarding Irina Natapov, M.D.
Docket No. 09-172

Dear Ms. Hannon:

Pursuant to our conversation on May 8, this letter will confirm that I have been retained by Dr. Natapov to represent her in matters before the Massachusetts Board of Registration in Medicine.

I also wish to confirm our conversation in which you kindly agreed to extend the time for Dr. Natapov's response to your letter of April 13, 2009, from May 13, 2009 until May 22, 2009. Thank you very much for your consideration in this regard.

Very truly yours,


Colin J. Zick

IRINA NATAPOV, M.D.
ALEXEYENKO MEDICAL ASSOCIATES PC
24 STATE STREET
LYNN, MASSACHUSETTS 01901
(781) 581-6181

May 18, 2009

MAY 19 2009
MASSACHUSETTS
BOARD OF REGISTRATION
IN MEDICINE

Via Overnight Delivery

Ms. Paula Hannon
Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Re: Complaint by _____ regarding Boris Sokolovskiy
against Irina Natapov, M.D., Docket No. 09-172

Dear Ms. Hannon:

I am writing in response to the letter I received from the Board of Registration in Medicine (the "Board") dated April 13, 2009. That letter contained a complaint that the Board received from a Ms. _____ regarding the care and treatment of her father, my patient _____ . I will describe below the relevant facts and the circumstances of my involvement in Mr. _____ 's care. I believe that a complete presentation of the facts will show that Ms. _____ 's complaint is without any basis in fact or in applicable medical standards.

The complaint that Ms. _____ filed with the Board alleges that Mr. _____ suffers from decreased platelet count that went untreated but which should have been treated over time. This complaint appears to be a simple (and to some degree understandable) reflect of a grieving daughter in response to her father's cancer diagnosis.¹

¹ According to Kubler-Ross, there are seven stages to the "Grief Cycle":

- Shock stage: Initial paralysis at hearing the bad news.
- Denial stage: Trying to avoid the inevitable.
- Anger stage: Frustrated outpouring of bottled-up emotion.
- Bargaining stage: Seeking in vain for a way out.
- Depression stage: Final realization of the inevitable.
- Testing stage: Seeking realistic solutions.
- Acceptance stage: Finally finding the way forward.

Before I address the specifics of the care provided to Mr. _____, however, I wish to briefly describe my professional background. I have been licensed as a physician in Massachusetts since 1996 and I am an active member of the medical staff at North Shore Medical Center's Union Hospital. During the time I have practiced medicine, I have never been the subject of any complaint to this (or any) licensing board, nor have I been the subject of any disciplinary action.

I first met Mr. _____ in November 2000. I had come to know his daughter through her business, and I believe it was due to that familiarity and the fact that I am a Russian speaker (Mr. _____ speaks no English) that he came to see me. At the time of his first visit with me, he was 70 years old. While he had multiple medical issues (including diabetes and hyperlipodemnia), he was active and functioning well for a person of his age. He was also under the care of a cardiologist at this time, as he had had coronary artery bypass surgery in 1996.

In advance of my first visit with Mr. _____, I obtained his chart from North Shore Medical Group. In reviewing the chart, I noted that he had a history of low platelet counts. However, his chart indicated (and my initial examination confirmed) that he was asymptomatic - he had been living with this low platelet count for many years and it was not effecting him in any significant way. Nevertheless, during our first appointment, I discussed this issue with him and conferred about my preferred approach, which was to monitor his platelet count and treat it if there were adverse changes to it or he began to experience symptoms due to it. I continued this treatment approach from 2001 into 2008. See Exhibit A (my notes of his January 9, 2001 and January 23, 2001 visits). All through that time, I monitored him for the symptoms of low platelet counts (e.g., fatigue and weakness, bruises that develop easily, bleeding gums or nosebleeds, headaches, bloody stool or urine, petechiae, or ecchymoses), but observed none.² His platelet counts remained somewhat below what is usually deemed normal, but were stable throughout this period. As a result, I continued on the course of care that I discussed with Mr. _____ -- monitoring for changes in the count or in the appearance of symptoms that suggested his platelet count was so low that it was causing him harm.

In late 2008, Mr. _____ changed cardiologists (I understand this change was to move to a Russian speaker, just as when he started seeing me). This new cardiologist sent him for a carotid ultrasound, which found a mass of plaque that the new cardiologist determined should be surgically removed. As part of the pre-surgical process, Mr. _____ was sent for a chest x-ray, which showed metastatic cancer. The ultimate source of that cancer was determined to have originated in Mr. _____'s left kidney.

As noted in the enclosed "Medical Oncology Progress Note" from North Shore Medical Center Cancer Center, even now the mass on Mr. _____'s kidney is not palpable and he is "completely asymptomatic." See Exhibit B. The note does not question the prior diagnosis of Mr. _____'s low platelet count nor does it question the prior course of care provided by me in that regard. The note states that a variety of treatments are available for Mr. _____'s

² See MedLine Plus: Thrombocytopenia, available at <http://www.nlm.nih.gov/medlineplus/ency/article/000586.htm>.

cancer and are being considered. Most importantly, there is nothing in the note that suggests any proven treatment options are currently unavailable to Mr. _____ due to his low platelet count.

Ms. _____'s complaint centers not around any well-known or accepted treatment. Rather, the subsequent consultation at Dana Farber Cancer Institute confirms that "[t]here is no standard therapy for papillary kidney cancer" See Exhibit C. Instead, Ms. _____'s complaint is that an unproven, unnamed new drug, still in Phase II trials,³ appears not to be indicated due to her father's low platelet count. Even in this regard, the oncologist for Mr. _____ (Dr. _____) left open the possibility that his platelet count could be raised to make Mr. _____ eligible for the trial with that experimental drug.

None of the physicians who have seen Mr. _____ in the past several months have questioned my approach to his low platelet count. Nor has any physician stated that a drug currently in Phase II clinical trials will cure the cancer that the 78 year old Mr. _____ is facing. I sympathize with Ms. _____ and Mr. _____, and wish them the best; however, I strongly believe that Ms. _____'s complaint regarding the care I provided to Mr. _____ is entirely without merit.

Sincerely,



Irina Natapov, M.D.

³ This unapproved drug appears to be in Phase II trials, and therefore far from certain to make an impact on Mr. Sokolovskiy's cancer. In Phase II trials, the experimental study drug or treatment is given to a group of people (100-300) to see if it is effective and to further evaluate its safety. See <http://clinicaltrials.gov/ct2/info/understand#Q19>. However, successful Phase III trials are still necessary to evaluate the drug with large groups of people (1,000-3,000) to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and collect information that will allow the experimental drug or treatment to be used safely. It is only after a Phase III trial that a drug can apply for FDA approval. For this particular drug, new of the Phase II study is just now being made public. According to a May 11, 2009 press release, there is a "Phase II study of 2 dosing regimens of GSK 1363089 (GSK089), a dual MET/VEGFR2 inhibitor, in patients (pts) with papillary renal carcinoma (PRC)." Dr. R. Srinivasan, National Cancer Institute; Poster presentation on May 31." Available at <http://www.bio-medicine.org/medicine-news-1/Research-Findings-on-Nine-GlaxoSmithKline-Cancer-Compounds-to-be-Presented-at-ASCO-2009-45314-1/>. See Exhibit D. This suggests that the drug in question is far from proven.

EXHIBIT A

EXHIBIT B

EXHIBIT C

EXHIBIT D

Navigation Links
Biology News
Medicine News
Biology Products
Medicine Products
Biology Definition
Medicine Definition
Biology Technology
Medicine Technology
Biology Dictionary
Medicine Dictionary

Biology Navigation
AIDS/HIV
Bioinformatics
Biotechnology
Biochemistry
Cancer
Cell Biology
Developmental Biology
Ecology
Environment
Evolution
Food Technology
Gene
Genetics
Genomics
Health/Medicine

Medical Navigation
Abortion
Aches
ADHD
Addiction
Alcohol
Allergy
Alternative Medicine
Alzheimer's Dementia
Anxiety/Stress
Arthritis
Autism
Bacteria
Blood
Bird Flu/Avian Flu
Bones

HOME >> MEDICINE >> NEWS

Research Findings on Nine GlaxoSmithKline Cancer Compounds to be Presented at ASCO 2009

Date: 5/11/2009 [Outline] [RSS & Subscription]

Kidney Cancer Treatment
Learn about oral treatment for Adv. Kidney Cancer. View the MOA.
www.AdvancedRCCTreatment.com

Drug Pipeline
Daily Drug Pipeline Updates Detailed Company Profiles
www.biopharminsight.com

Prostate Cancer Treatment
Groundbreaking Techniques for the Highest Known Cure Rates Worldwide.
www.ProstRcision.com

Data Include First Presentation of Phase III Progression Free Survival Results for Pazopanib in Kidney Cancer

LONDON and PHILADELPHIA, May 11 /PRNewswire/ -- GlaxoSmithKline (GSK) Oncology announced that new clinical data from nine of its oncology molecules will be featured in various presentations at the annual meeting of the American Society of Clinical Oncology (ASCO) in Orlando beginning May 29. The presentations cover GSK Oncology research in solid and blood tumor treatment, supportive care and prevention

Ad by Google
In an array of difficult to treat tumors including kidney cancer, advanced breast cancer, leukemia and prostate cancer.

The following investigational presentations reflect the broad spectrum of GSK-sponsored studies being presented at this year's ASCO Congress:

Kidney Cancer: New, pivotal Phase III data surrounding the GSK oral, investigational, angiogenesis/VEGF inhibitor, pazopanib. Also, Phase II data on GSK089, a new investigational compound with a MET/VEGFR2 mechanism of action.

- ORAL PRESENTATION: "A randomized, double-blind Phase III study of pazopanib in treatment naive and cytokine-pretreated patients with advanced renal cell carcinoma (RCC)." Dr. C. Sternberg, San Camillo and Forlanini Hospitals, Italy; Presentation on June 1.
- "A Phase II study of 2 dosing regimens of GSK 1363089 (GSK089), a dual MET/VEGFR2 inhibitor, in patients (pts) with papillary renal carcinoma (PRC)." Dr. R. Srinivasan, National Cancer Institute; Poster presentation on May 31.

Gastric Cancer: Investigational Phase II study exploring GSK089 in gastric cancer.

- ORAL PRESENTATION: "Assessment of 2 dosing schedules of GSK1363089 (GSK089), a dual MET/VEGFR2 inhibitor, in metastatic gastric cancer (GC): Interim results of a multicenter phase II study." Dr. M. A. Shah, Memorial-Slo

SOURCE GlaxoSmithKline
Copyright©2009 PR Newswire.
All rights reserved

0
GOOD

Page: 1 2 3 4 5

Related medicine news :

1. [Stanford researchers find culprit in aging muscles that heal poorly](#)
2. [Children of depressed moms do better when dad is involved, SLU researcher finds](#)
3. [UCLA researchers identify markers that may predict diabetes in still-healthy people](#)
4. [Mayo Clinic researchers discover new diagnostic test for detecting infection in prosthetic joints](#)
5. [New research shows how chronic stress worsens neurodegenerative disease course](#)
6. [New research explores newborn in-hospital weight loss](#)
7. [Research may unlock mystery of autism's origin in the brain](#)
8. [Bipolar disorder relapses halved by Melbourne researchers](#)
9. [HIV's impact in Zimbabwe explored in new research](#)
10. [U.S. Research Funding Continues to Flatten as U.S. Health Costs Climb - in August 31 Science](#)
11. [Cell that triggers symptoms in allergy attacks can also limit damage, Stanford researchers find](#)

Post Your Comments: (View All Comments)

*Name:

Breaking Medicine News(10 mins):

- [0] [Health and Advocacy Leaders Mobilize to Bring Attention to Atrial Fibrillation, a Costly and Misunderstood Cardiovascular Disease](#)
- [0] [Carnival Corporation & plc Reports Financial Impact of Itinerary Changes Responding to H1N1 Influenza Mexico Travel Advisory; Plans Rapid Return to Popular Mexican Ports](#)
- [0] [Shire Expands Gastrointestinal Patient Assistance Program for Uninsured or Unemployed Americans](#)
- [0] [New Spray Could Benefit Cystic Fibrosis Patients](#)

Other Medicine News:

Breaking Medicine Technology:

- [0] [Boehringer Ingelheim to Present New Phase II Clinical Data on Two Lead Oncology Compounds at ASCO 2009](#)
- [0] [TYRX Presents Early Clinical Results from AIGISRX\(TM\) Antibacterial Envelope Retrospective Registry](#)
- [0] [Spherix Elects New Independent Director, and Elects Chairman of the Board](#)
- [1] [New MADIT II Clinical Data Analysis Shows Long-Term Survival Benefit for Implantable Defibrillator Therapy](#)

Other Medicine Technology:

Medicine Products:

- LabScheduler Version 3.0
- CryoCor CryoBlator Cryoablation Catheters
- Q-Pulse Compliance and Improvement Management
- Thermoline™ Blood Component Thawing System MT-210



Commonwealth of Massachusetts
Board of Registration in Medicine

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

July 22, 2009

Irina Natapov, M.D.
24 State Street
Lynn, Massachusetts 01901

Re: Docket Number: 09-172

Dear Dr. Natapov:

The Complaint Committee of the Board of Registration in Medicine met on June 3, 2009, and considered the above-referenced matter. They determined that no further action is warranted and the matter has been closed.

Despite the decision to close the above complaint, the Board reserves the right to reopen the complaint should you commit any violations of Board statutes or regulations in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "P. Paige".

Peter G. Paige, M.D.
Complaint Committee Chair

PH/jec



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Current Status: Active

License Expiration Date: 4/26/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America

Home Address:

Business Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America
(781) 581-6181

3) Email Address: _____

4) Fax Number: (781) 599-3229

5) Specialties
Internal Medicine
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Jewish Rehab Ctr for the Aged/N Shore	paradise rd, swampscott ma



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Life Care Center
Private Office
Union Hospital

**11) Care of patients in Massachusetts
Average weekly hours involved in:**

- a) inpatient care 30 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	01/01/2011	01/01/2012	Claims made with tail coverage

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

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

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

22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Compliance with Legal Responsibilities

Online profile:

- I have reviewed my Physician Profile and confirm that the information is accurate.
- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
 - 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
 - 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
 - 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
 - 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
 - 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
 - 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
 - 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
 - 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
 - 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
 - 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- 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.**
- 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.**

04.20.2011

To: Attn. Sharlene Morelli
fax: 781-876-8383

From: Irina Natapov M.D.
Lic # 151665 MA

I did not get my vallet card
by adress: 24 Wade Street, Lynn, MA
01901

Could you please to send it
to my home adress

If you have any questions,
please call:
cell -

Thank you

04.20.2011

SI 14 05/04/11





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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Current Status: Active

License Expiration Date: 4/26/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America

Home Address:

Business Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America
(781) 581-6181

3) Email Address:

4) Fax Number: (781) 599-3229

5) Specialties
Internal Medicine
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Jewish Rehab Ctr for the Aged/N Shore	paradise rd, swampscott ma



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Life Care Center
Peabody Glen Nursing Center
Private Office
Union Hospital

**11) Care of patients in Massachusetts
Average weekly hours involved in:**

- a) inpatient care 30 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	01/01/2013	01/01/2014	Claims made with tail coverage

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

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues

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

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

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



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

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

22) Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if you are renewing your license for the first time, please answer Yes)

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Irina Natapov, M.D.

License No.: 151665



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Compliance with Legal Responsibilities

Online profile:

- I have reviewed my Physician Profile and confirm that the information is accurate.
- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
 - 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
 - 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
 - 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
 - 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
 - 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
 - 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
 - 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
 - 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
 - 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
 - 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.
 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- 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.**
- 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.**



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171



DEVAL L. PATRICK
Governor

JOHN W. POLANOWICZ
Secretary

KRISTIN L THORN
Acting Medicaid Director



To:	Consumer protection Coordinator	From:	
Office:	Board of Registration in Medicine	Office:	EOHHS
Phone:		Phone:	
Fax:	781-876-8381	Fax:	
Date:	8/14/2013	Pages: (including cover sheet)	5
Re:	Complaint	CC:	

RN

Urgent For Your Review Please Reply ASAP Please Comment

• **Comments:** This complaint was received at our office on 8/14/2013. Please update us on this matter.
Thank you

If you have any problems with the transmission of this fax, please call _____ Thank you.

RN at

This facsimile transmittal may contain information that is privileged, confidential, or exempt from disclosure under applicable law and is intended for the use of only the individual or department to which it is addressed. If you are not the recipient, or the employee or the agent responsible for the delivery of this transmittal to the intended recipient, please notify the sender by telephone at the above number and destroy the attached documents. Anyone other than the intended recipient is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.



Complaint/Grievance Form

Any problem or complaint that you may have about MassHealth is important to us. If a customer service representative or a MassHealth enrollment center representative is not able to resolve your problem, or if you are unhappy with the resolution, we are interested in hearing about it.

Please complete the information below and send it to the address on this form. In our efforts to resolve your grievance, we may contact you and your health-care provider or, in some instances, the appropriate regulatory agencies.

Please print.

Name (First) _____ (Last) _____
 Mailing address (Street) _____
 (City) _____ (State) _____ (Zip) _____
 Phone number _____
 Social security number or MassHealth ID number _____

I would like to make a complaint about the following individual or organization:

Name (First) IRINA (Last) NATAPOV
 Address (Street) 24 State St
 (City) LYNN (State) Mass. (Zip) 01901
 Phone number UNKNOWN

In the space below, please tell us about your complaint or problem. Be as specific and brief as possible and, whenever possible, give the date(s) that the event occurred. (If you need more space, please add additional sheets to this form.)

On Thurs, July 11th, 2015, I had an appt. with Dr. NATAPOV to determine if I was eligible for MassHealth. I was ushered into a RU, where my vitals were taken and I was told the Dr. would be right in. When she came in, she told me to remove all clothing except my panties, and I said fine. She then told me to remove an ace bandage from my left knee. I told her that my Br's office had put it on the day before, that I had injured my knee, had fluid under the knee cap and was told to keep it on for 2 weeks. She told me to remove it anyway. She left the room. When she returned, she looked at my chart,

Please see Complaint Form for Mass Health.



Commonwealth of Massachusetts Board of Registration in Medicine

COMPLAINT FORM

Return this form to: Consumer Protection Coordinator Board of Registration in Medicine 200 Harvard Mill Square, Suite 330 Wakefield, MA 01880 Fax: (781) 876-8381

Please type or print legibly in ink. You may use the attached lined page to explain your complaint or attach your own paper to this form. Any additional information you would like to submit with your complaint must be in paper or electronic form and will not be returned. Do not send objects, tapes, or X-rays. If you have any questions, please call our Consumer Protection Unit at (781) 876-8200.

PHYSICIAN INFORMATION (Complete one physician for each Complaint Form)

Physician information form with fields for last name (Natapov), first name (ERLINA), middle initial (G), street address (24 State St), city (Lynn), state (Ma), zip code (01930), physician's medical specialty (Obstetrics & Gynecology), and telephone number (781-581-6181).

PATIENT INFORMATION

Patient information form with fields for gender (female), last name, first name, middle initial, street address, city, state, zip code, date of birth, daytime telephone number, location of treatment (Office), date of incident (July 11, 2013), and length of time under care.

COMPLAINANT INFORMATION (Complete ONLY if different from the patient information)

Complainant information form with a note about confidentiality, fields for gender, last name, first name, middle initial, street address, city, state, zip code, and relationship to the patient.

ACKNOWLEDGEMENT

I acknowledge that, by submitting this complaint and signing this form, the Board of Registration in Medicine may (1) obtain medical records and other information relating to this complaint; and/or (2) refer my complaint to other appropriate regulatory or law enforcement authorities. I understand that the Board may provide a copy of my complaint and all attachments to the physician.

Complainant's signature

Date

Please detail the steps you took to try to resolve the problem.

I was in too much pain to do much other than cry. My guide and is professional! You can tell by her attitude that she feels that everyone that comes into her office is a fake and a fraud. I TOLD her about my back procedure 2 days earlier and my knee injury and she went out of her way to test it, to cause me physical pain. So wrong!!

Please supply any other information to clarify this grievance/complaint.

Cost from other side: Commenting on my back injury. I told her I had a procedure done 2 days earlier, on the 9th she proceeded to use her reflex hammer on my spine as I cried out in pain, trying to reach for the reflex hammer. She then walked around front and used it on both knees knowing full well I had a knee injury!! She finished with "exam" told me to dress, and told me I needed mental help and that I was perfectly healthy - find to go down the hall and have my eyes checked.

Signature: _____

Date: 8/12/13

Please send this completed form to: MassHealth Operations
Attn: Laura Basso
100 Hancock Street, 6th floor
Quincy, MA 02171

FOR OFFICE USE ONLY

Assigned to: _____

Log number: _____

Final resolution: _____

Date resolved: _____

LMS

8/12/13

Please, if you have any problem reading this at all, feel free to call me and I will do my best to explain what happened.

I was so distraught and upset when I wrote it, that some of my writing may be too hard to read.

My number is:

Thank You.



DEVAL L. PATRICK
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

September 3, 2013

Re: Irina Natapov, M.D.
Docket Number: 13-339

Dear Ms. _____ :

The Board of Registration in Medicine has received your complaint regarding the above named physician. The physician has been asked to respond in writing to your complaint.

If you wish to bring additional information about your complaint to the attention of the Board, please provide it to me in writing at the address above. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

Once our review of your complaint has been completed, you will receive a letter informing you of the outcome.

Thank you for bringing this matter to the attention of the Board.

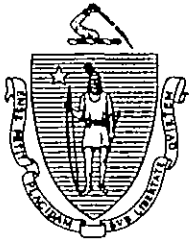
Very truly yours,

A handwritten signature in cursive script that reads "Paula Hannon".

Paula Hannon
Consumer Protection Coordinator

PH/df





DEVAL L. PATRICK
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

November 22, 2013

RE: Irina Natapov, M.D.
Docket Number: 13-339

Dear Ms

Thank you for the information that you provided to the Board of Registration in Medicine. A copy of your complaint, referenced above, was sent to the physician, who was required to respond in writing. Enclosed please find a copy of the physician's response.

After considering this matter on November 20, 2013, the Board's Complaint Committee did not recommend disciplinary action and closed the complaint. However, your complaint and the physician's response will be placed in the physician's file at the Board.

Thank you again for bringing this matter to the Board's attention.

Very truly yours,

A handwritten signature in cursive script that reads "Paula Hannon".

Paula Hannon
Consumer Protection Coordinator

PH/df





DEVAL L. PATRICK
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

September 3, 2013

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Irina Natapov, M.D.
24 State Street
Lynn, Ma 01901

7011 1150 0001 3795 2001

Re: Docket Number: 13-339

Dear Dr. Natapov:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. Please provide a written response to the issues raised in the enclosed material. As part of your response, please provide a copy of the patients' medical records. You should also provide any other materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response and any attachments.

The Health Insurance Portability and Accountability Act (HIPAA) provides that otherwise protected health information may be disclosed to a health oversight agency for activities that include disciplinary actions. See 45 CFR section 164.512 (d). The Board clearly meets the definition of a health oversight agency. See 45 CFR section 164.501.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee.

Your response must be sent to me within thirty days of this letter. Upon receipt, your response will be reviewed to determine the course of action. You will be notified of this decision. Thank you for your attention to this request.

Very truly yours,


Paula Hannon
Consumer Protection Coordinator

PH/df
Enclosure



IRINA NATAPOV, M.D.
ALEXEYENKO MEDICAL ASSOCIATES PC
24 STATE STREET
LYNN, MASSACHUSETTS 01901
(781) 581-6181

RECEIVED
OCT 3 2013
Board of Registration
in Medicine

October 2, 2013

By Overnight Delivery

Ms. Paula Hannon
Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Re: Complaint by _____ against Irina Natapov, M.D., Docket No.
13-339

Dear Ms. Hannon:

I am writing in response to the letter I received from the Board of Registration in Medicine (the "Board") dated September 3, 2013. That letter contained a complaint that the Board received from _____ regarding her interactions with me on July 11, 2013. I will describe below the relevant facts and the circumstances of my involvement with Ms. _____. I believe that a complete presentation of the facts will show that Ms. _____'s complaint is without any basis in fact or in applicable medical standards.

Before I address the specifics of my interactions with Ms. _____, I wish to briefly describe my professional background. I have been licensed as a physician in Massachusetts for over 15 years (since 1996) and I am an active member of the medical staff at North Shore Medical Center's Union Hospital. During the time I have practiced medicine, I have never been the subject of any substantiated complaint to this (or any) licensing board, nor have I been the subject of any disciplinary action.

Vitaly important to an understanding of Ms. _____'s complaint is the fact that she was seen as part of an independent medical exam (IME). This is not a traditional doctor-patient encounter, but rather a court-managed procedure that is designed to be independent and unbiased:

When the mental or physical condition ...of a party, or of a person
..., is in controversy, the court in which the action is pending may

order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control.

Massachusetts Rules of Civil Procedure, Rule 35. As such, different standards apply to an IME than to a traditional patient examination. According to the American Board of Independent Medical Examiners, a physician conducting an IME should:

- introduce him/herself to the examinee as the examining physician;
- advise the examinee they are seeing him/her for an independent medical examination, and the information provided will be used in assessment and presented in a report;
- provide the examinee with the name of the party requesting the examination;
- advise the examinee that no treating physician-patient relationship will be established;
- explain the examination process;
- provide adequate draping and privacy if the examinee needs to remove clothing for the examination;
- refrain from derogatory comments; and
- close the examination by telling the examinee that the examination is over and ask if there is further information the examinee would like to add.

See American Board of Independent Medical Examiners, Guidelines of Conduct, available at HYPERLINK "<http://www.abime.org/node/21>" <http://www.abime.org/node/21>. I believe I conducted the examination of Ms. Walo in accordance with these standards:

I introduced myself to Ms.

I advised her that she was being seen for an IME and explained that the information would be used to assess her medical status;

I confirmed that she was referred by the UMass Disability Evaluation Service;

I explained that I was not her treating physician and would not be treating her;

I outlined the examination process;

I provided draping and I and my staff left the room while Ms. undressed and put on her examination gown;

I did not make any derogatory comments about her or her medical conditions; and

I closed the exam by asking if there was anything she wished to say to me about her medical conditions. She expressed despair that she was "missing work."

Overall, I spent over 45 minutes with Ms. . This included an initial interview, which was conducted before she undressed, and then the IME.

With regard to the specific allegations Ms. made in her complaint, I note that there is no specific allegation of improper behavior, merely an emotional description of the IME that I conducted, the individual elements of which are mandated and over which I have no control.

Ms. complained that I asked that she take off an ace bandage she was wearing on one knee; however, it is a requirement of a complete IME that such bandages be removed. While Ms. did inform me that she had injured her knee and was receiving treatment for it, she did not indicate that there was any reason why she could not remove the bandage or that she was experiencing extreme pain in her bandaged knee. In fact, I had observed her walk into the exam room, and based on my observation of her gait, there was no indication that disrobing, standing for a short time, or being examined would be problematic for her. As I noted, "[s]he did not use any assistive device for ambulation." In fact, upon examination, there was no indication of anything abnormal in her knee joint.

Ms. 's primary complaint seems to be that I tested her for injuries during the IME, in particular that I tested her patellar reflex with a reflex hammer. I did not hit her knee hard, but only tapped it briefly. This should not have caused her pain. See "A Practical Guide to Clinical Medicine," published by the University of California, San Diego, available at [HYPERLINK "http://meded.ucsd.edu/clinicalmed/neuro3.htm"](http://meded.ucsd.edu/clinicalmed/neuro3.htm) <http://meded.ucsd.edu/clinicalmed/neuro3.htm> (Indicating that when conducting a patellar reflex exam, a physician should "[s]trike the tendon with a single, brisk, stroke. While this is done firmly, it should not elicit pain."). Ms. also complained that I tested both knees which, of course, was necessary to judge the functioning of both her uninjured and injured knee. Even so, Ms. was able to perform single leg raises with each leg up to 90 degrees, without evidence of pain or muscle weakness.

I was quite surprised and dismayed when Ms. began to cry during the exam. I have never had the subject of an IME crying during an exam before. I naturally asked Ms. what was wrong, and she responded that she was upset to be "missing work." I was concerned about her extensive and seemingly unprovoked crying and I did suggest she speak to a caregiver about it. However, I have no recollection whatsoever of discussing her mental health, let alone suggesting she seek any specific treatment. I also did not discuss what the conclusions from my exam would be and, as such, I certainly

never told her that she was "perfectly healthy."

Based on the facts set forth above, I do not believe there is any evidence to substantiate the complaint asserted by Ms. . I am at a loss to understand why Ms. would make assert this claim against me.

Sincerely,

A handwritten signature in black ink, appearing to read "Irina Natapov". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Irina Natapov, M.D.

Enclosure (records of IME exam)

EXHIBIT A: Records of IME exam

RECEIVED
OCT 3 2013
Board of Registration
in Medicine

PAGE 7

Ms. Paula Hannon
PAGE 2
October 1, 2013
Page

- PAGE 2 -
DOCPROPERTY "CUS_DocIDString" B4173495.2

DOCPROPERTY "CUS_DocIDString" B4173495.2

bcc: Colin J. Zick, Esq. (by U.S. Mail)

RECEIVED

OCT 3 2013

Board of Registration
in Medicine



DEVAL L. PATRICK
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

November 22, 2013

Irina Natapov, M.D.
24 State Street
Lynn, MA 01901

RE: Docket Number: 13-339

Dear Dr. Natapov:

The Complaint Committee of the Board of Registration in Medicine met on November 20, 2013, and considered the above-referenced matter. We have decided not to recommend disciplinary action and closed the complaint.

However, information concerning this matter will be kept on file at the Board. We reserve the right to reopen the complaint should you commit any violation of Board statutes or regulations in the future.

Sincerely,

A handwritten signature in cursive script that reads "Gerald B. Healy".

Gerald B. Healy, M.D.
Complaint Committee Chair

GBH/df





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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Current Status: Active

License Expiration Date: 4/26/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America

Home Address:

Business Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America
(781) 581-6181

3) **Email Address:**

4) **Fax Number:** (781) 599-3229

5) **Specialties**
Internal Medicine
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
None Reported

10) **Work Sites**

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
AVIV NH	Lynnfield st, Peabody MA



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Life Care Center
Private Office
Union Hospital

**11) Care of patients in Massachusetts
Average weekly hours involved in:**

- a) inpatient care 30 hrs/wk
- b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	01/01/2015	01/01/2016	Claims made with tail coverage

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

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
- b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
- b) Have any criminal offenses/charges against you been resolved during this time period?
- c) Are there any criminal charges pending against you today?
- d) Are any Application of Issuance of Process pending against you?

18) Other Issues

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

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

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



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

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

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

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Irina Natapov, M.D.

License No.: 151665



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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.

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 Renewal Application**

Physician Name: Irina Natapov, M.D.

License No.: 151665

Current Status: Active

License Expiration Date: 4/26/2017

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America

Home Address:

Business Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America
(781) 581-6181

3) Email Address:

4) Fax Number: (781) 599-3229

5) Specialties
Internal Medicine

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DFA)	Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
correction	MA
Jewish Rehab Ctr for the Aged/N Shore	Peabody MA



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Life Care Center
Private Office

Lynn, Ma

11) Care of patients in Massachusetts

Average weekly hours involved in:
a) inpatient care 5 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	01/01/2017	01/01/2018	Occurrence Policy

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

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
- b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
- b) Have any criminal offenses/charges against you been resolved during this time period?
- c) Are there any criminal charges pending against you today?
- d) Are any Application of Issuance of Process pending against you?

18) Other Issues

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

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

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



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

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

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

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

25) Electronic Health Records Proficiency

I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse

Have you completed training to recognize and report suspected child abuse or neglect?

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Compliance with Legal Responsibilities

Online profile:

- I have reviewed my Profile and I will contact the Board for assistance with certain information.
- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
 - 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
 - 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
 - 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
 - 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
 - 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
 - 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
 - 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
 - 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
 - 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
 - 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- 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.**
- 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.**
-

151466 (Free)

To:
MA Board of Registration in Medicine
Data Repository Unit
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Fax: 781-876-8380

April 2, 2017

Dear Sir/Madam:

Please correct the physician profile with the following information:

Hospital affiliations: NSMC (North Shore Medical Center).

Thank you,
Dr. Natapov.

Please see the attached profile.



Massachusetts Board of Registration in Medicine Physician Profile

This Profile is not available for public release until 04/26/2017.

Irina Natapov, M.D.

Physician Information

Except for the License information, this information has been reported by Dr. Natapov.

License Number	151665
License Status	Active
License Issue Date	09/25/1996
License Renewal Date	04/26/2019
NPI Number	1619979408
Accepting New Patients	Yes
Accepts Medicaid	Yes
Primary Work Setting	Private Office
Business Address	24 State Street Lynn, MA 01901 United States of America
Business Telephone	(781) 581-6181
Translation Services	Russian Spanish
Insurance Plans Accepted	Blue Cross Blue Shield Cigna Harvard Pilgrim Health Care Medicaid Medicare Neighborhood Health Plan Tufts United HealthCare
Hospital Affiliations	None Reported

Both The Joint Commission and the National Committee on Quality Assurance consider the Massachusetts Board of Registration to be a primary source provider for license status information.

Education & Training

The Education and Training information was verified as of the License Issue Date above.



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Current Status: Active

License Expiration Date: 4/26/2019

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America

Home Address:

Business Address: 24 State Street
Lynn
Massachusetts - 01901
United States of America
(781) 581-6181

3) Email Address:

4) Fax Number: (781) 599-3229

5) Specialties
Internal Medicine

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Jewish Rehab Ctr for the Aged/N Shore Life Care Center	Peabody MA



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

North Shore Medical Center - Salem Hospital Salem
Private Office
Private Office Lynn, Ma

**11) Care of patients in Massachusetts
Average weekly hours involved in:**

- a) inpatient care** 5 hrs/wk
- b) outpatient care** 32 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Medical Professional Mutual Ins Co	01/01/2019	01/01/2020	Occurrence Policy

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

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
- b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
- b) Have any criminal offenses/charges against you been resolved during this time period?
- c) Are there any criminal charges pending against you today?
- d) Are any Application of Issuance of Process pending against you?

18) Other Issues

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

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

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



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

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

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

Yes



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

23) Do you have a medical or physical condition that currently impairs your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

25) MassHealth Enrollment Status

I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- 16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.



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

Physician Name: Irina Natapov, M.D.

License No.: 151665

- 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.
- 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.