RECEIVED
Board of Registration in Medicine

Commonwealth of Massachusetts

Board of Registration in Medicine

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

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: State of Alabama Board of Med. Examiners

ADDRESS: PO Box 946

CITY: Montgomery STATE: AL ZIP: 36101-0946

(TYPE OR PRINT) PHYSICIAN'S NAME: JOHN G. CURINGTON MD

BUSINESS ADDRESS: One Medical Group 1790 Broadway, Suite 1802

CITY: New York STATE: NY ZIP: 10019

MASSACHUSETTS LICENSE NUMBER: 225376

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: May 8, 2015

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

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FEB 9 2016
Board of Registration in Medicine

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Florida Board of Medicine

ADDRESS: 4052 Bald Cypress Way, Bin C03

CITY: Tallahassee STATE: FL ZIP: 32399-3253

PHYSICIAN'S NAME: John Gibson Curington MD

BUSINESS ADDRESS: ______

CITY: ______ STATE: ______ ZIP: ______

MASSACHUSETTS LICENSE NUMBER: 225376

SIGNATURE OF PHYSICIAN: [signature]
Signed under the penalties of perjury

DATE: 5 of February 2016

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

2/9/16 1049 10.00 CM

Massachusetts Physician Renewal Application

Physician Name: John G Curington **License No.:** 225376

PART A

1) Current Status: Active (circled) **Renewal Due Date:** 01/17/2006 **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 OK

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DEC 02 2005
Board of Registration in Medicine

☐ *Check here to change this address*

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

2b) HOME ADDRESS OK

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 OK
1055 Commonwealth Ave
Boston, MA 02215

Phone: (617) ~~616~~-1660 617-616-1600

☐ *Check here to change this address*

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (617) 616-1600

Business address cannot be a Post Office Box

3) E-mail Address: ______

4) Fax Number: none - I work as an independent contractor and don't have a fax machine

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Family Practice	☐	
	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☑	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: John G Curington **License No.: 225376**

(See Renewal Instructions, page 4.)
7) Drug License Numbers, if any:
a) Massachusetts:
b) Federal (DEA):
c) Federal (DEA) XS:

Please make corrections as necessary
8a) Other states where you are now licensed to practice (Abbr.)
CA
8b) States where you were previously licensed (Abbr.)

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*
Principal Work Setting: Clinic Change to:
Please enter the *approximate* number of work hours at your principal work setting: 25

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

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
	☐	✓		25 hours
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ___ hrs/wk
b) outpatient care 0 hrs/wk Change to: 25 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: Marsh USA Inc Change to: Marsh USA Inc 1166 Avenue of the Americas NY, NY 10036

Policy dates: From 11/01/1976 To 12/31/05 ← this is renewed every year on Jan 1.
(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: John G Curington **License No.: 225376**

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: John G Curington **License No.:** 225376

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.

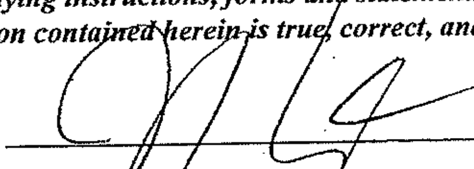
(See Renewal Instructions, page 9.)

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: 

Date: Nov 8, 2005

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: John G Curington **License No.:** 225376

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. ← see attached 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: [signature] Date: Nov, 8, 2005

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: John G Curington **License No.: 225376**

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.

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

- [x] My current NPI is: 1780675876
- [ ] I have personally applied for an NPI.
- [ ] 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.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 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:	207Q00000X	Family Practice
Provider Taxonomy:	207Q00000X	Family Practice
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.

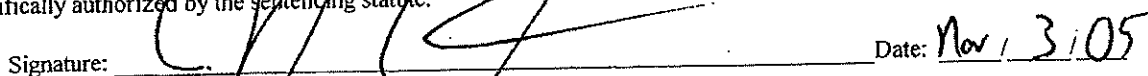
Social Security Number: ___ ___ ___

State of Birth (if US): ____________ Country of Birth (if outside the US): ____

Gender: [x] Male [ ] Female

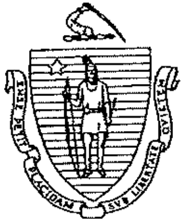
Penalties for Falsifying Information on the National Provider Identifier Application

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.



Signature: ____________ Date: Nov 3, 05

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



Commonwealth of Massachusetts

Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9858

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

RECEIVED
APR 11 2006
Board of Registration
in Medicine

John G Curington M.D

April 05, 2006

License No. **225376**

Dear Dr. Curington:

On your most recent license renewal application, you either supplied the Board of Registration in Medicine with your National Provider Identifier (NPI) number, stated that you have applied for this number or authorized the Board to apply for an NPI number on your behalf. The Center for Medicare Services (CMS) requires authorization from the physician in order to disseminate the NPI number to health care providers or authorized agencies.

Please sign and date the authorization statement to allow the Board of Registration in Medicine to provide your NPI number to any authorized agency, hospital, health plan, or health organization. You must mail this authorization to the Board of Registration in Medicine, 560 Harrison Avenue, G-4, Boston, Massachusetts, 02118.

Please return the original signed NPI authorization form in the envelope provided. CMS requires an original signed authorization form for dissemination of your NPI number to health providers or authorized agencies. We cannot accept a faxed copy of this form. Thank you.

Authorization for NPI Dissemination

I authorize the Board of Registration in Medicine to provide my NPI to any authorized agency, hospital, health plan, or health organization.

Signature: ______________________ Date: April 8, 2006

License Number: 225376

Renewal Date: 02/14/2006

Massachusetts Physician Renewal Application

Physician Name: John G Curington, M.D. **License No.:** 225376

PART A

1) Current Status: Active **Renewal Due Date:** 01/17/2008 **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

correct

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Board of Registration in Medicine

☐ *Check here to change this address*

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

2b) HOME ADDRESS

correct

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
Harvard University Health Services
75 Mount Auburn Street
Cambridge, MA 02138-4960

Phone:

☐ *Check here to change this address*

Business Address: 1055 Commonwealth Ave
City/Town: Boston State: MA
Zip: 02215 Country: USA
Business Telephone: (617) 616-1600

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number:

Correct your E-mail and Fax Number below:

Fax (617) 616-1675

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

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Family Medicine	ABMS	Family Practice	☐
			☐
			☐
			☐

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

Massachusetts Physician Renewal Application

Physician Name: John G Curington, M.D. **License No.:** 225376

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: ____
b) Federal (DEA): ____
c) Federal (DEA) XS: ____

Please make corrections as necessary

8) Other states where you are now licensed to practice
CA – California License A66341

9) States where you were previously licensed
~~CA~~

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
			☐
			☐
1055 Commonwealth Avenue			☐
Boston, MA 02215	Boston	MA	☐
(617) 616-1600			☐

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk
b) outpatient care ~~X~~ hrs/wk Change to: 40 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: Marsh USA, Inc Change to: ____

Policy dates: From 12/31/06 To 01/01/08 (renewed by office every year)

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

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

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

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

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

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

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

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

Massachusetts Physician Renewal Application

Physician Name: John G Curington, M.D. **License No.: 225376**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

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.)

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.

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

Massachusetts Physician Renewal Application

Physician Name: John G Curington, M.D. **License No.: 225376**

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: Nov 5, 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.

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 it 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.

CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

Mass.Gov

• online services • agencies • elected officials • help

Back | Home | How to Read a Profile

Massachusetts Board of Registration in Medicine Physician Profile

John G. Curington, M.D.

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

License Status:	Active
License Issue Date:	8/3/2005
Accepting New Patients:	No
Accepts Medicaid:	No
Primary Work Setting:	Clinic
Business Address:	~~Harvard University Health Services 75 Mount Auburn Street Cambridge, MA 02138-4960~~ → 1055 Commonwealth Avenue Boston, MA 02215
Phone:	~~None Reported~~ (617) 616-1600
Translation Services Available:	English French Spanish
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	None Reported

II. **Education & Training**

Correct

Medical School:	University of California, Davis School of Medicine
Graduation Date:	1997
Post Graduate Training:	Santa Rosa Family Med Res Prg - Intern - Family Practice (7/1/1997-7/15/2000) Sutter Med.Ctr. of Santa Rosa - Resident - Family Practice (7/1/1998-6/30/2000)

III. **Specialty**

Correct

Area of Specialty:	Family Medicine

IV. **Board Certifications**

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

Correct

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Practice	

V. **Honors and Awards**

Alpha Omega Alpha Medical Honor Society 1997
Ama Physician Recognition Award 2004 , ~~200~~ 2005, 2006, 2007

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

JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

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

Correct

VIII. Disciplinary and/or Criminal Actions

Correct

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. Curington 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. Curington 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. Curington 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 617-654-9830
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
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

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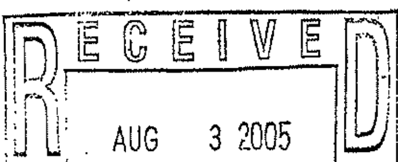
JOHN CURINGTON M.D.
Lic. 225376 MA
Lic. A66341 CA

225376

Curington, John
Massachusetts Application # 225376



Full License Application

JUL 19 2005
BOARD OF
REGISTRATION IN MEDICINE

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

MEDICAL EDUCATION VERIFICATION

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

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

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

Print or Type Name: CURINGTON (Last name) JOHN (First Name) GIBSON (Middle Initial) Social Security No: ____

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

Name of Medical School: UC Davis School of Medicine

Address: One Shields Avenue City: Davis State or Province: California 95616

(530) 752-3105 student records
(530) 752-4046 registrar

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

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

____

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Yale University

Undergraduate School Address: YALE University
Office of the Registrar
PO Box 208321
New Haven, CT
06520-8321
(203) 432-2330

(Continued on page 2)

Massachusetts Application # 225376

Full License Application

Enrollment and Participation: Our records indicate that CURINGTON, JOHN G.

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	9 / 20 / 93	6 / 17 / 94	6 /24 /96	6 /13 /97
	6 / 27 / 94	6 / 16 / 95	/ /	/ /
	7 / 3 / 95	6 / 14 /96	/ /	/ /

The applicant attended 165 total weeks *or* ______ total months (must be included) **of not less than 32 weeks in each academic year of continuing on-campus education.**

check one [X] was awarded a degree in Doctor of Medicine on (month/day/year) 6 /13 /97

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

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

YES **NO**

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: * No such information in our files-completed to the best of our knowledge

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: [signature]

Print Name: Michael Wilkes, M.D., Ph.D.

Title: Vice Dean for Medical Education

Date: 8 /2 /05 Telephone: (530) 752-3800

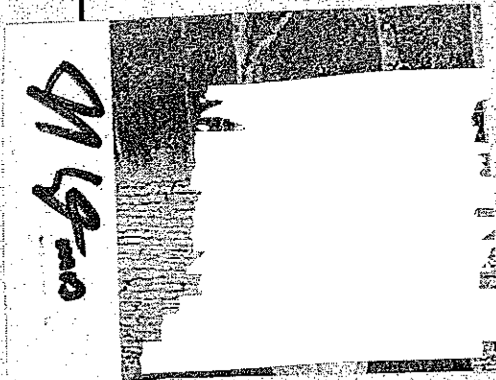
This form will not be accepted unless it is stamped with the institutional seal or notarized.

Commonwealth of Massachusetts--Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

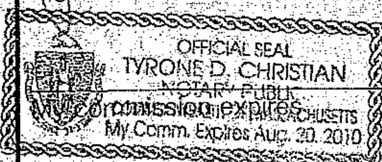
PHOTOGRAPH



Signature of applicant

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

Signature of Notary



My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

JOHN G. CURINGTON, MD.
(name of applicant)

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

Signature of Certifying Physician

220226 — License Number
MA — State

NIRA POLLOCK
Type or print name clearly

Address: Division of Infectious Diseases, 110 Francis St., Lowry Medical Building, Suite 6B
City: Boston
State: MA Zip: 02215
Telephone: (617) 632-7706
Date: 4/12/05

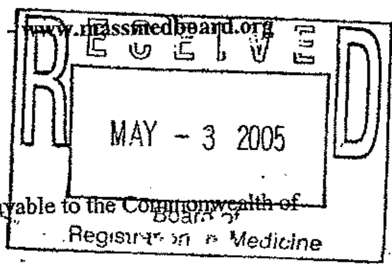
Instructions to the certifying physician: **Return the completed form to the applicant in a sealed envelope with your signature across the seal.**

Seal Verified
DATE: 6/6/05
INITIALS: TDC

JE
5/6/05
45/04

Application #: 225376
Date of Issue: ______

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



FULL LICENSE APPLICATION

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

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

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

CURINGTON, JOHN GIBSON

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

☑ M.D ☐ D.O. ☐ Ph.D ☐ Other degree ______ ☒ Male ☐ Female

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

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

Date of Birth: Month Day Year

Social Security Number: ______

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

Home Address: ______ Number and Street

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

Business Address: ______ Number and Street

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

Business Telephone: (617) 447-5549, ext. ______ Home Telephone: ______

E-mail Address: ______

Preferred Mailing Address: ☒ Business Address ☐ Home Address

PRINT NAME: John G. Curington MD PAGE 2 OF 3

Pre-medical School

Facility: Yale University Degree: B.A. From 08/01/84 To 06/15/1987
Street: PO Box 1604-A City: New Haven State: Connecticut 06520

Facility: Bryn Mawr College Degree: Post-Bac 07/15/90 06/15/91
Street: Post Bac Pre-Med Program 101 North Merion Avenue City: Bryn Mawr State: Pennsylvania 19010-2899 (610) 526-7350

Medical School

Facility: University of California at Davis Degree: M.D. From 6/15/92 To 06/13/1997
Street: UCD Medical School One Shields Avenue City: Davis State: California 95616 (530) 752-2416

Facility: Degree: / / / /
Street: City: State:

Date of medical school graduation: 06 / 13 / 1997

I took 5 years in med school as part of the UCDavis "splitter program." I taught anatomy, did extra clinical courses, and had a positive learning experience.

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

Postgraduate Education:

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

Facility: Community Hospital Position: PG1 From 06/15/97 To 06/15/98
Street: 3324 Chanate Road City: Santa Rosa State: California 95616

Facility: Sutter Medical Center of Santa Rosa Position: PG2, PG3 06/15/98 06/15/00
Street: 3324 Chanate Road City: Santa Rosa State: California 95616

Facility: Position: / / / /
Street: City: State:

Facility: Position: / / / /
Street: City: State:

Facility: Position: / / / /
Street: City: State:

note,
Community Hospital and Sutter Medical Center are the same facility. During my intership years, our hospital was bought and the name changed.

PRINT NAME: John G. Curington MD

Hospital Affiliations and Employment

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

Facility / Street	Position / City	From	To / State	
Facility: Planned Parenthood	Position: physician	10/15/00	current	(925) 676-0505
Street: 2185 Pacheco Street	City: Concord	State: CA	94520	
Facility: Warrack Hospital	Position: ER Physician	05/15/00	04/15/02	(707) 523-7195
Street: 2449 Summerfield Road	City: Santa Rosa	State: CA	95405	
Facility: Women's Health Specialists	Position: physician	01/15/00	08/15/00	(707) 537-1171
Street: 1469 Humboldt Road, Suite 200	City: Chico	State: CA	95928	
Facility: Sutter Medical Center	Position: Resident physician	06/15/97	07/15/00	(707) 576-4075
Street: 3324 Chanate Road	City: Santa Rosa	State: CA	95404	

1. List other states (abbreviations) where you are currently or have ever been licensed: CA
2. Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
3. List Board Certification(s): American Board of Family Practice — Certification date: 07/14/2000 board # 103020 — Certification date: __/__/__
4. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: My wife just got a job doing research at the Mass. General, so we moved to Massachusetts.
6. Name of Facility:
7. Address: City:
8. Anticipated starting date in Massachusetts: __/__/__ → as soon as possible!

Affidavit of Applicant

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

Signature of Applicant [signature]

Date: April 27, 2005

Rev: 10/21/2002

Employment History for
John G. Curington MD

Planned Parenthood, Shasta Diablo
Position: Clinic Physician
556 Vallombrosa Avenue
Chico, California 95926
530-342-8367
Oct 2000-current

Planned Parenthood, Golden Gate Affiliate
Position: Physician and Clinical Instructor
815 Eddy Street, Suite 300
San Francisco, California 94109
415-441-9947
Oct 2002-current

Warrack Hospital Emergency Department
Position: Emergency Department Physician
2449 Summerfield Road
Santa Rosa, California 95405
707-523-7195
May 2000-April 2002

Women's Health Specialists
Position: Contract Physician
1469 Humboldt Road, Suite 200
Chico, California 95928
530-891-1917
Jan 2000-August 2000

Sutter Medical Center of Santa Rosa
Position: Resident Physician
3324 Chanate Road
Santa Rosa, California 95404
(707) 576-4075
June 1997-July 2000

08/02/2005 10:21 FAX 16174269358 Board of Medicine 003/003

Curington
Massachusetts Application # 225376

Full License Application

RECEIVED JUL 19 BOARD OF REGISTRATION IN MEDICINE

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

MEDICAL EDUCATION VERIFICATION

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

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

Applicant's Signature: [signature] Date of Birth

Print or Type Name: CURINGTON (Last name) JOHN (First Name) GIBSON (Middle Initial) Social Security No:

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

Name of Medical School: UC Davis School of Medicine

Address: One Shields Avenue City: Davis State or Province: California 95616
(530) 752-3105 student rec.
(530) 752-4046 registrar

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

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

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Yale University

Undergraduate School Address: YALE University
Office of the Registrar
PO Box 208321
New Haven, CT
06520-8321
(203) 432-2330

(Continued on page 2)

Massachusetts Application # 225376

Full License Application

Enrollment and Participation: Our records indicate that CURINGTON, JOHN G.

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES: FROM	TO	FROM	TO
9 / 20 / 93	6 / 17 / 94	6 / 24 / 96	6 / 13 / 97
6 / 27 / 94	6 / 16 / 95	/ /	/ /
7 / 3 / 95	6 / 14 / 96	/ /	/ /

The applicant attended 165 total weeks *or* ______ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one [X] was awarded a degree in Doctor of Medicine on (month/day/year) 6 / 13 / 97

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

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

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: * No such information in our files-completed to the best of our knowledge

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: [signature]

Print Name: Michael Wilkes, M.D., Ph.D.

Title: Vice Dean for Medical Education

Date: 8 / 2 / 05 Telephone: (530) 752-3800

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

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

MEDICAL EDUCATION VERIFICATION

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

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

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

Print or Type Name: Baumer (Last name) Joane (First Name) G. (Middle Initial) Social Security No: ______

Other Name(s): Joan Elizabeth-Goforth Baumer (Please type or print name(s))

Name of Medical School: University of California at Davis School of Medicine

Address: 2315 Stockton Blvd City: Sacramento State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

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

______

Premedical Education: Does your school have a premedical school education requirement? [X] Yes [ ] No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Scripps College Stirling University

Undergraduate School Address: Claremont, CA Stirling, Scotland

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Baumer	Joane	G
(type or print the applicant's name): (Last name)	(First name)	(Middle initial)

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

ATTENDANCE DATES: FROM	TO	FROM	TO	
9 / 28 / 72	6 / 14/73	6 / 30 /75	6 15 /76	*Extended for
7 / 5 / 73	6 /12 /74	6 / 28 /76	06 17 /77	Research
~~7 / 8 / 74~~	~~6 /13 /75~~	/ /	/ /	

The applicant attended 165 total weeks or ______ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one [X] was awarded a degree in Doctor of Medicine on (month/day/year) 6/ 17 /77

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

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

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

COMMENTS: *Completed tp the best of our knowledge

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: [signature]

Print Name: Michael Wilkes, M.D., Ph.D.

Title: Vice Dean for Medical Education

Date: 8 /1 /05 Telephone: (530) 752-3800

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

08/02/2005 10:22 FAX 16174269358 Board of Medicine ☑001

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

TRANSMISSION OK

TX/RX NO	3110
RECIPIENT ADDRESS	15307547295
DESTINATION ID	
ST. TIME	08/02 10:20
TIME USE	02'33
PAGES SENT	3
RESULT	OK

Commonwealth of Massachusetts

Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

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

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

FAX#: 617-426-9358

FACSIMILE TRANSMITTAL FORM

TO: Elena

FROM: Jackie

DATE: 8/2/05 TIME:

FAX#: 530-754-7295

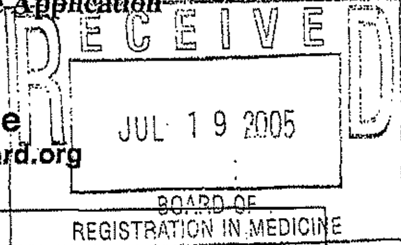
NUMBER OF PAGES INCLUDING COVER SHEET: 3

MAKE ADDITIONAL COPIES FOR:

NOTES: On next Page Please answer all questions correctly in Box See Arrow & fax Back to 617-426-9358; Also form should be Fed-ex by tomorrow, with Seal @ Bottom (see Arrow) Dr.

Curington, John
Massachusetts Application # 225376

Full License Application



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

MEDICAL EDUCATION VERIFICATION

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

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

Applicant's Signature: [signature] Date of Birth

Print or Type Name: CURINGTON (Last name) JOHN (First Name) GIBSON (Middle Initial) Social Security No:

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

Name of Medical School: UC Davis School of Medicine

Address: One Shields Avenue City: Davis State or Province: California 95616
(530) 752-3105 student record
(530) 752-4046 registrar

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

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

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Yale University

Undergraduate School Address: Yale University
Office of the Registrar
PO Box 208321
New Haven, CT
06520-8321
(203) 432-2330

(Continued on page 2)

5

Curington, John
Massachusetts Application # 225376

Full License Application

Enrollment and Participation: Our records indicate that CURINGTON, JOHN G.

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES: FROM	TO	FROM	TO
9 / 20 / 93	6 / 17 / 94	6 / 24 / 96	6 / 13 / 97
6 / 27 / 94	6 / 16 / 95	/ /	/ /
7 / 3 / 95	6 / 14 / 96	/ /	/ /

The applicant attended 165 **total weeks** *or* ____ **total months** (must be included) **of not less than 32 weeks in each academic year of continuing on-campus education.**

check one [XX] was awarded a degree in Doctor of Medicine on (month/day/year) 6 /13 /97

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

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

YES **NO**

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the *applicant* ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: * No such information in our files

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: [signature]

Print Name: Jay Conner

Title: Manager, Office of Medical Education

Date: 7 /13 /05 Telephone: (530) 752-3800

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

...al Verified

...TE: 7/24/05

01 09/16/05 88

Commonwealth of Massachusetts
Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

:ERRY HEALEY
TENANT GOVERNOR

:Y ACHIN AUDESSE
:CUTIVE DIRECTOR

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

530-754-7295
Cov letter
attn: elena

FAX#: 617-426-93

FACSIMILE TRANSM

TO: Elena

FROM: Jackie

DATE: 8/2/05 **TIME:**

FAX#: 530-754-7295

NUMBER OF PAGES INCLUDING COVER SHEET: 3

MAKE ADDITIONAL COPIES FOR:

NOTES: On next page please answer all questions correctly in box see arrow & fax back to 617-426-9358, Also form should be fed-exd by tomorrow, with seal @ bottom (see arrow) Dr. Covington will be contacting you re.. fedex

CONFIDENTIALITY NOTE

The documents accompanying this facsimile transmission contain information from the Board of Registration in Medicine which may be CONFIDENTIAL AND/OR PRIVILEGED. The information is intended to be for the use of the individual or entity named on this transmittal sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this information is prohibited. If you have received this facsimile in error, please notify us by telephone immediately and return the original message to us at the above address by First Class Mail via the U.S. Postal Service. Thank you.

If there are problems receiving this transmittal, please contact sender.

Commonwealth of Massachusetts
Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
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MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

June 6, 2005

John G Curington, M.D.

Re: Application Number 225376

Date Application Received: 06/06/2005

Dear Dr. Curington :

Your application for a full medical license in Massachusetts was received on the above date.

The Licensing Unit will assist you in expediting the processing of your application, however, please be advised that it can take up to twelve (12) weeks to process an application. Throughout this process, we will provide you with periodic updates regarding the status of your license application.

You will receive a notification of missing documents for your full license application in four weeks. Please be advised that if your full license application is incomplete after 6 months, you will be required to update the application and specific documents that are 6 months old. For additional licensing information, you may access the Board's website at www.massmedboard.org .

Sincerely,

Mrs. Janice D. Cummings

Licensing Staff

JOHN CURINGTON MD

PROFESSIONAL EXPERIENCE

2000 - current Planned Parenthood — Concord, California
Clinic Physician
- Family planning, first-trimester abortions, vasectomies and nurse-practitioner supervision in several California communities. Also one of the core trainers in the TEACH program instructing residents in abortion technique in collaboration with the University of California.

2000 - 2002 Warrack Hospital — Santa Rosa, California
Emergency Department Physician
- Worked solo in this small-hospital community ER doing broad spectrum of emergency medicine.

1997 - 2000 Sutter Medical Center — Santa Rosa, California
Resident Physician in Family Practice
- Broad range of Family Practice including outpatient clinics, obstetrics, procedures, emergency medicine and urgent care.

1995 Spring University of California — Davis, California
Associate Instructor in Anatomy
- Gross anatomy and histology for undergraduate students. Managed six teaching assistants and wrote and administered lab examinations.

1994 - 1997 Outdoor Adventures — Davis, California
Sea Kayak Guide

1991 - 1992 Planned Parenthood — Fresno, California
Surgical Services Coordinator

1991 Summer Valley Children's Hospital — Fresno, California
Pathology Assistant

1988 - 1990 Chaulk Ambulance — Boston, Massachusetts
Emergency Medical Technician

1987 - 1988 Centro Presente — Cambridge, Massachusetts
English Teacher for Adult Students

EDUCATION

1992 – 1997 University of California at Davis — Davis, California
Doctor of Medicine, with honors

1990 – 1991 Bryn Mawr College — Bryn Mawr, Pennsylvania
Post-Baccalaureate Pre-Med Program

1984 – 1987 Yale University — New Haven, Connecticut
BA degree in Linguistics, Magna Cum Laude

1986 and 1988 Bogaziçi Üniversitesi — Istanbul, Turkey
Summer Program in Turkish Language

AWARDS AND ACTIVITIES

Alpha Omega Alpha Medical Honor Society

Regents Scholarship

National Merit Scholarship

Rensselaer Math and Science Award

Colombian Guitar Study in Bogota

CERTIFICATIONS

ABFP (American Board of Family Practice)

ACLS (Advanced Cardiac Life Support)

NRP (Neonatal Resuscitation Program)

ALSO (Advanced Life Support in Obstetrics)

ATLS (Advanced Trauma Life Support)

PROFESSIONAL ORGANIZATIONS

American Academy of Family Physicians

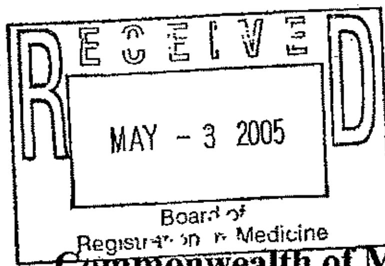
California Medical Association

American Medical Association

LANGUAGES

fluent English and Spanish

utilitarian French and Turkish



FULL LICENSE APPLICANT

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

EVALUATION FORM

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

Signature of applicant: [signature] Date: 03/01/2005

Please PRINT your name JOHN G. CURINGTON MD

Name of facility: Planned Parenthood State California

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

1. How long have you known the applicant? From: 09/ /2002 To: PRESENT
   A. In what capacity? ☑ supervisory ☐ colleague ☐ affiliated in practice ☐ other: ______
   B. Date(s) of applicant's affiliation at facility: From: 10/15/00 To: current
   C. Applicant's Status: ☐ Intern ☐ Resident ☐ Fellow ☐ Staff Member ☑ Other Contract Physician
2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? ☑ No ☐ Yes (if "yes" please explain below)

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

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

(Continued on page 2)

FULL LICENSE APPLICANT PAGE 2

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

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

Excellent clinical and ambulatory surgical skills. A favorite among patients & staff. Wonderful communication skills with patients.

6. The above comments are based on the following:

☑ Close personal observation

☐ General impression

☐ A composite of previous evaluations by other physicians

☑ Other Annual evaluation including complications data, patient & staff satisfaction

7. **RECOMMENDATIONS:**

☑ I recommend John Cunington for licensure in Massachusetts.

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

☐ I do not recommend ________ for licensure in Massachusetts

I certify that at the time of completion of the above physician's training, and/or during my association with the physician, he/she was competent to practice medicine.

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

Print Your Name: MAUREEN PAUL Date: 3/9/05 7/25/05

Academic title or position: CHIEF MEDICAL OFFICER Phone number: (415) 202-7220

Specialty/Service or Department: MEDICAL SERVICES DEPT. PLANNED PARENTHOOD GOLDEN GATE

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

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

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

Excellent clinical and ambulatory surgical skills. A favorite among patients & staff. Wonderful communication skills with patients.

6. The above comments are based on the following:

☑ Close personal observation

☐ General impression

☐ A composite of previous evaluations by other physicians

☑ Other Annual evaluation including complications data, patient & staff satisfaction

7. **RECOMMENDATIONS:**

☑ I recommend John Curington for licensure in Massachusetts.

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

☐ I do not recommend ______ for licensure in Massachusetts

I certify that at the time of completion of the above physician's training, and/or during my association with the physician, he/she was competent to practice medicine.

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

Print Your Name: MAUREEN PAUL Date: 3/9/05

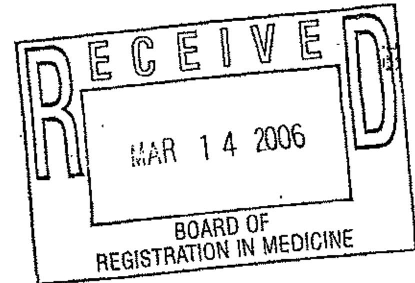
Academic title or position: CHIEF MEDICAL OFFICER Phone number: (415) 202-7220

Specialty/Service or Department: MEDICAL SERVICES DEPT. PLANNED PARENTHOOD GOLDEN GATE

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

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 54
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.caldocinfo.ca.gov



March 10, 2005

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
560 HARRISON AVE G4
BOSTON MA 02118

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	JOHN GIBSON CURINGTON
License No.:	A 66341
Issued:	August 21, 1998
Exam Type:	A written examination
Expiration Date:	February 28, 2006
Status:	Renewed/current

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

JEHadnot

Joyce E. Hadnot
Acting Chief, Licensing Program

SEAL

Seal Verified
DATE: 6/6/05
INITIALS: J.D.C

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: March 1, ~~2004~~ 2005

Print or Type Name: John G. Curington MD

Name of Institution: Santa Rosa Sutter Family Practice Residency Program
3324 Chanate Road, Santa Rosa, CA 95404

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Sutter Medical Center of Santa Rosa Family Practice Residency Program

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

Enrollment and Participation: Our records indicate that John G. Curington (Print applicant's name) participated in the following program:

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	Family Prac	7/97	6/98	Y	ACGME
Residency	2+3	Family Prac	7/98	6/00	Y	ACGME

(Continued on page 2)

POSTGRADUATE VERIFICATION FORM PAGE - 2

APPLICANT'S NAME: John G. Curington, M.D.

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

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

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

COMMENTS:______

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: [signature] MD

Print Name: Marshall Kubota MD

Academic Title: Clinical Prof. UCSF

Telephone: (707) 576-4070 Today's Date: 03/09/05

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

Seal Verified

DATE: 6/6/05

INITIALS: J.D.C.

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

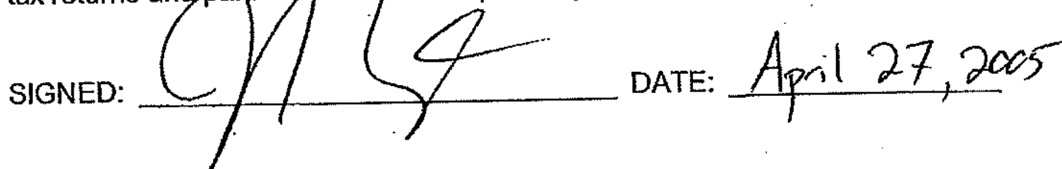
MEDICARE - TAX FORM

INSTRUCTIONS:

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

I, John G. Curington,
(type or print name)

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



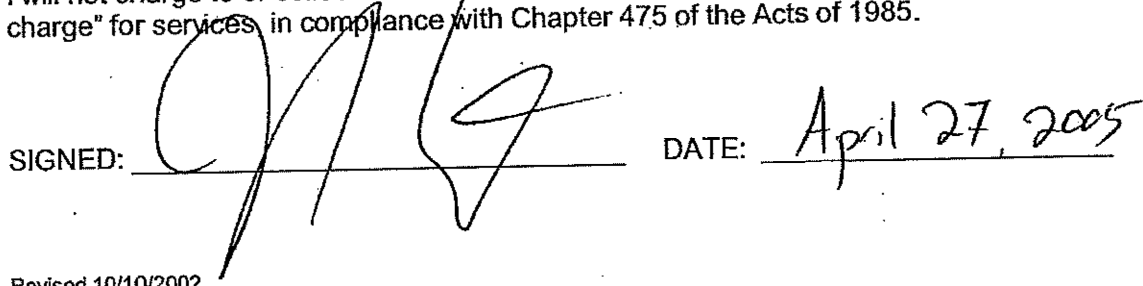
SIGNED: ______________ DATE: April 27, 2005

Social Security Number:

****

Massachusetts General Laws Chapter 112, §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.



SIGNED: ______________ DATE: April 27, 2005

Revised 10/10/2002

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, JOHN GIBSON CURINGTON MD
(type/print your complete name)

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

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

Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4
Boston, Massachusetts 02118
Attention: Licensing

Immunity and Release

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

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

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

[signature] April 27, 2005

Applicant's Signature | Date of Signature

~~JOHN~~ CURINGTON, JOHN G.

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

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

SUPPLEMENT FORM

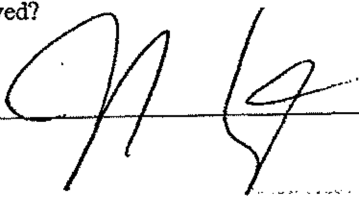
PRINT NAME: JOHN G. CURINGTON MD DATE: 04/27/05

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

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

Applicant's Signature: [signature] Date: 04/27/2005

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

Applicant's Signature:  **Date:** 04/27/05

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplemental pages for questions #16-A to 19. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

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

If your responses to Questions 1-19 change while your application is pending, you must immediately notify the Board of the new information.

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

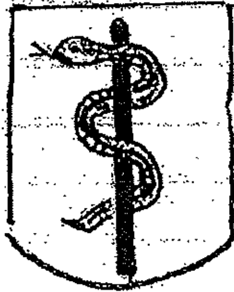
Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting Child Support.

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

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

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

Applicant's Signature: ______________________ **Date:** 04/27/05



August 8, 2005

John Curington MD

license # 225376

Board of Registration in Medicine
ATTN: Profiles
560 Harrison Ave, G-4
Boston, MA 02118
617-654-9800

Dear folks at the Mass Med Board,

I just received my Massachusetts medical license and a Physician Profile form. Please note the corrections.

Also, please do not publish my home address on the internet. I work in California and have continued to do so while I was waiting for my Massachusetts license. Now that I have my license, I am applying for jobs in Massachusetts.

My work address is 2185 Pacheco Street
Concord, CA 94520

Please use this address on your website instead of my home address. When the California medical board accidentally released our home addresses, I had an aggressive young man visit my house at 6am wanting some vicodin to sustain his habit. As you could imagine, I have no desire to experience such visits again.

I will send you my new work address as soon as I get a job in Massachusetts. Thank you for your understanding in this matter.

Sincerely,

Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118
www.massmedboard.org - Fax (617) 426-9358

SEP 21

10/03/05 124

CHANGE OF ADDRESS REQUEST

Instructions: Type or print your name and address. You must list all addresses and indicate whether it is a "new" address of or "no change."

Please note: When you change your home or principal business address you are required to notify the Board within 30 days. The Board makes a licensee's business address available to the public and includes it in the physician Profile. If you do not have a business address, the Board will make public and use your mailing address, even if that mailing address is the same as your home address. The Board may also release a home address upon written request from a party upon a showing of good cause, for example, when an attorney seeks a home address for purposes of service of process. Thank you.

PHYSICIAN'S NAME: John Curington License #: 225376
(print name)

Mailing Address: *(check one)* ☐ New address ☒ No change

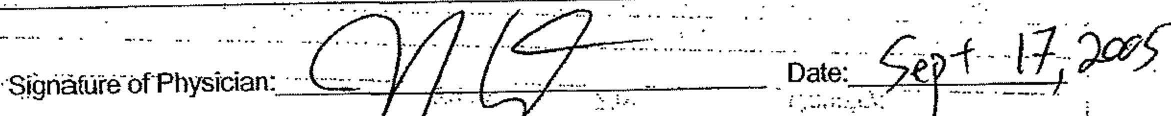
Street Address:
Apartment # Telephone #:
City: State: Zip: Country:

Home Address: *(check one)* ☐ New address ☒ No change

Street Address:
Apartment # Telephone #:
City: State: Zip: Country:

Business Address: *(check one)* ☒ New address ☐ No change

Business Name: John Curington MD Telephone #: (617) 616-1660
Street Address: 1055 Commonwealth Ave
City: Boston State: MA Zip: 02215 Country: USA



Signature of Physician: ________ Date: Sept 17, 2005

Fax the completed form to the Board of Registration in Medicine at (617) 426-9358. If you need a new wallet card with your new mailing address, please attach your current wallet card to this form and mail to the Board of Registration in Medicine at the above listed address.

UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

STUDENT HEALTH SERVICE
UNIVERSITY OF CALIFORNIA, SAN DIEGO

9500 GILMAN DRIVE, 0039
LA JOLLA, CALIFORNIA 92093-0039
(858) 534-3300
FAX: (858) 534-0814

August 21, 2009

John G Curington MD
UCSD Student Health Service (0039)
9500 Gilman Drive
La Jolla, CA 92093-0039
(858) 534-3300

AUG 25 2009
Board of Registration in Medicine

225376

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

Dear folks at the Board of Registration in Medicine,

Please note my change of address. My new address is above. Though it looks a little strange, the (0039) is important in the campus address because it is used as a postal code by the delivery folks. Please change my address in your records and on-line.

My previous address was:
1055 Commonwealth Ave.
Boston, MA 02215

This address is no longer valid.

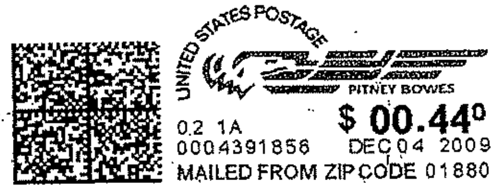
Thank you for your help with this address change.

Much appreciated,

Accredited by **Accreditation Association for Ambulatory Health Care, Inc.**

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

RETURN SERVICE REQUESTED



225376

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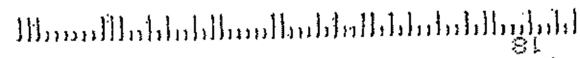
FORWARD TIME EXP RTN TO SEND
CURINGTON'JOHN

RETURN TO SENDER



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