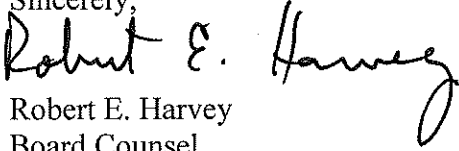


The Board reserves the right to retrieve any exempted, privileged, or otherwise protected materials inadvertently included in this production. Any such production is not, and shall not be considered or deemed, a waiver of any applicable privileges or protections from disclosure.

The Board now considers this request closed.

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

Sincerely,

A handwritten signature in cursive script that reads "Robert E. Harvey". The signature is written in black ink and is positioned to the right of the typed name.

Robert E. Harvey
Board Counsel

Enclosure



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Current Status: Active

License Expiration Date: 2/8/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address: 759 Chestnut St
Springfield
Massachusetts - 01199
United States of America
(413) 794-5606

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
---------------	---------------	------------------

8) **Other states where you are now licensed to practice**
Connecticut

9) **States where you were previously licensed**
None Reported

10) **Work Sites**

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

WorkSite	Location
Baystate Medical Center	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

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

- a) inpatient care 24 hrs/wk
b) outpatient care 24 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Medical Center Self Insured	10/01/2017	10/01/2018	Claims made with tail coverage

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

Yes

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

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

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

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

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



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Office Based Surgery

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

You indicated that you are a Level II office

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

Diagnostic hysteroscopy

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

Yes



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Compliance with Legal Responsibilities

Online profile:

I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Current Status: Active

License Expiration Date: 2/8/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

759 Chestnut St
Springfield
Massachusetts - 01199
United States of America
(413) 794-5606

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Planning Fellowship
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
---------------	---------------	------------------

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

9) **States where you were previously licensed**
Connecticut

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

WorkSite	Location
Baystate Medical Center	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Planned Parenthood

Springfield

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

- a) inpatient care 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Health Insurance Co. Ltd.	10/01/2019	10/01/2020	Claims made with tail coverage

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

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?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

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

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

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



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

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

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

- 23) Do you have a medical or physical condition that currently impairs your ability to practice medicine?
- 24) Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?



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

Physician Name: Neena T Qasba, M.D.

License No.: 271176

25) MassHealth Enrollment Status

I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

26) Domestic Violence and Sexual Violence Training Requirement

Have you completed training and education on the issue of domestic violence and sexual violence? Yes



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

Compliance with Legal Responsibilities

Online profile:

I have reviewed my Physician Profile and confirm that the information is accurate.

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Neena T Qasba, M.D.

License No.: 271176

-
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
 - Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.

90-Day Form

APR 13 2017
Board of Podiatry
Medicine

Dear Doctor,

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your full license is issued on January 1, 2014, you will be required to renew your full license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below and return this form with your Full License application.

Thank you.

Please select one of the boxes below:

- Do not hold my Full License Application; send it to the Board as soon as it is completed.
- Hold my Full License Application until it is within the 90-day time period.

My birthdate is _____
Month Day Year

Signature: Chenna Claska

Today's Date: 3 / 30 / 2017
Month Day Year

Please return this form with your Full License Application. If you do not submit this form with your Full License Application, your completed Full License Application will be forwarded to the Board for approval at the next Board meeting. Thank you.

RECEIVED

APR 5 2017

271176

Board of Registration

Board of Registration in Medicine

in 200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880

Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

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

Type of License [X] Initial Full License [] Administrative License [] Volunteer License

Check One: [X] U.S./Canadian Graduate [] International Graduate

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

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

[X] 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. [X]

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

Social Security Number: Date of Birth: Month Day Year

NPI (National Provider Identifier) Number: 1417248253

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

*Mailing Address: Telephone: City State/Province/Territory Zip (or postal) Code

Home Address: Telephone: City State/Province/Territory Zip (or postal) Code

Business Address: 310 Cedar St, FM13320 Telephone: 203-755-7223 City: New Haven State/Province/Territory: CT Zip (or postal) Code: 06520

E-mail Address: Fax number: N/A

Are you applying for licensure through FCVS? [] Yes [X] No

* The Board will use your Mailing Address for all correspondence

Date Received: 4/5/17

Check #: 135134

Check Amount: \$ 600.00

Title: CM

Pre-medical School

Name: Johns Hopkins University Degree: B.A. Year: 2002 Year: 2006
Street: 3400 N. CHARLES ST. City: Baltimore State: MD

Name: _____ Degree: _____ Year: _____ Year: _____
Street: _____ City: _____ State: _____

Medical School

Name: University of Connecticut Degree: M.D.
Street: 2103 Farmington Ave City: Farmington State: CT

Name: _____ Degree: _____
Street: _____ City: _____ State: _____

Medical School Graduation Date: 06 / 2011 5/2011 NQ edited 5/31/2017
Month Year

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. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

Facility: Indiana University PGY Year: 1-4 From: 7/2011 To: 06/2015 NQ edited 5/31/2017
Specialty: UPBYN City: Indianapolis State: IN

Facility: Yale University PGY Year: Fellow From: 7/2015 To: 06/2017 NQ edited 5/31/2017
Specialty: Family Planning Fellowship City: New Haven State: CT

Facility: _____ PGY Year: _____ / _____
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ / _____
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ / _____
Specialty: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination).

<u>Examination</u>	<u>Number of attempts</u>	<u>Passed (P) or Failed (F)</u>	
USMLE Step I	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step II	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
USMLE Step III	1	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F
NBME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
NBME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 1		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Component 2		<input type="checkbox"/> P	<input type="checkbox"/> F
FLEX Pre-1985		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
NBOME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 1		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 2		<input type="checkbox"/> P	<input type="checkbox"/> F
COMLEX Level 3		<input type="checkbox"/> P	<input type="checkbox"/> F
COMVEX		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Single		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Part I		<input type="checkbox"/> P	<input type="checkbox"/> F
LMCC – Part II		<input type="checkbox"/> P	<input type="checkbox"/> F
State Board Exam		<input type="checkbox"/> P	<input type="checkbox"/> F

(State of examination and year)

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical 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.

Facility:	<u>Yale New Haven Hospital</u>	Position:	<u>Fellow / Clinical Instructor</u>	From:	<u>07/2015</u>	To:	<u>07/2017</u>
Street:	<u>100 York St.</u>	City:	<u>New Haven</u>	State:	<u>CT</u>		
Facility:	_____	Position:	_____	From:	____/____	To:	____/____
Street:	_____	City:	_____	State:	_____		
Facility:	_____	Position:	_____	From:	____/____	To:	____/____
Street:	_____	City:	_____	State:	_____		

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

2. a) Are you certified by the American Board of Medical Specialties? Yes No
 b) Are you certified by the American Board of Osteopathic Medicine? Yes No

3. List Board Certification(s): None. Board eligible.

4. List your practice specialt(ies): OBGYN, Family Planning

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

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

7. Reason for requesting a Massachusetts medical license: physician position at Baystate Medical Center, Springfield, MA. OBGYN Department

8. Name of Facility: Baystate Medical Center
 Address: 759 Chestnut St. City: Springfield, MA

9. Anticipated starting date in Massachusetts: 08/31/2017

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

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

Signature of Applicant: Sheema Warba

3 / 30 / 2017
 Month Day Year

Boston University School of Medicine
Continuing Medical Education

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



Neena Qasba, MD
760 Quinnipiac Ave
New Haven, CT 06513
United States

Boston University School of Medicine

certifies that

Neena Qasba, MD

has participated in the enduring material titled

***SCOPE of Pain:
Safe and Competent Opioid Prescribing Education***

and is awarded 2 AMA PRA Category 1 Credit(s)[™]

Date Completed: April 2, 2017

Maximum Credits: 2
Total Credits Reported: 2
Risk Management Credit: 2
Opioid Credits: 2

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of 2 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only credit commensurate with the extent of their participation in the activity.

American Academy of Family Physicians (AAFP) Credits:
This Enduring Material activity, SCOPE of Pain: Safe & Competent Opioid Prescribing Education, has been reviewed and is acceptable for up to 2.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 02/16/2018. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

Daniel P. Alford, MD, MPH, FAAP, FASAM
Assistant Dean
Professor of Medicine

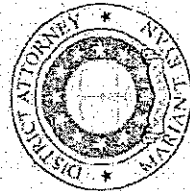
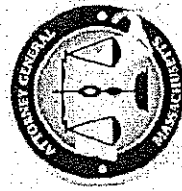
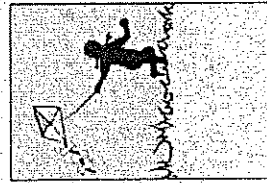
MANDATED REPORTER TRAINING

THIS CERTIFICATE IS AWARDED TO

Neena Qasba

For Completing the Middlesex Children's Advocacy Center's Online
Mandated Reporter Training: Recognizing and Reporting Child
Abuse, Neglect, and Exploitation

On April 2, 2017



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Neena Qasba
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Neena Qasba
Applicant's Signature

3/30/11
Date of Signature

Qasba, Neena T
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

- Participation in a Meaningful Use program as an eligible professional;
- Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
- Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
- Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

- who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
- for an Administrative License;
- for a Volunteer License;
- on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
- for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME:

Neena Dasba

DATE:

3/31/17

Neena T. Qasba, M.D.

Education

- 07/2015-present **Yale University School of Medicine, New Haven, Connecticut**
Department of Obstetrics, Gynecology, and Reproductive Sciences
Family Planning Fellow, Clinical Instructor in Obstetrics and Gynecology
- 7/2015-present **Yale School of Public Health, New Haven, Connecticut**
Master in Public Health- Health Policy and Management
- Health Policy Practicum with Medicaid Policy Office. Wrote policy brief and provider bulletin on coverage for immediate postpartum long-acting reversible contraception devices.
- 07/2011-6/19/2015 **Indiana University School of Medicine, Indianapolis, Indiana**
Department of Obstetrics and Gynecology
Resident Physician in Obstetrics and Gynecology
- Resident Award for Excellence in Family Planning (2015)
 - First Prize Resident Research Award (2014)
 - Ryan Program Resident Scholar (2013)
 - 4.0 award in medical student education – recognized for teaching medical students during OBGYN clerkship rotations
- 08/2007-05/2011 **University of Connecticut School of Medicine, Farmington, Connecticut**
Medical Doctorate
- University of Connecticut Provost's Award for Excellence in Public Engagement *Finalist* (2011) – Nominated for organizing public awareness events including the International Health and Human Rights film series and lecture events
 - American Medical Student Association Global Health Student Achievement Award (2011) – national award given to a medical student that promoted awareness of global health at their medical school.
 - University of Connecticut School of Medicine Urban Service Track (2007-2011) – participated in a multi-disciplinary educational track that included lectures and volunteer opportunities focusing on underserved populations
 - Gold Humanism Honor Society (2010) – recognized for demonstrating excellence in clinical care, leadership, compassion and dedication to service
 - University of Connecticut School of Medicine Summer Research Fellowship (2008) – pursued summer research project in Bolivia regarding health outcomes in a microcredit program
- 08/2002-05/2005 **Johns Hopkins University, Baltimore, Maryland**
Bachelor of Arts: Public Health-Natural Sciences concentration
Minors: Spanish and Global Studies
- Pontificia Universidad Católica de Ecuador, Quito, Ecuador (December, 2005)**
Spanish Language Diploma
- Phi Beta Kappa (2006) – graduated in top 10% of class
 - Outstanding Senior Award in Community Service (2006) – Given to select group of undergraduate students exhibiting commitment to a local community service project
 - Outstanding Public Health Student Award (2006) – Given to select few undergraduates in the Department of Public Health Studies for academic achievement
 - Baltimore City Health Commissioner's Commendation for Community Service (2005) – Given to the student leaders of *Programa Salud*, a student-run organization focused on health outreach/health education in the Latino community in Baltimore.

Research and International Health Experience

07/2015-present **Yale University School of Medicine, New Haven, Connecticut**

Department of Obstetrics, Gynecology, and Reproductive Sciences

Role: Primary Investigator

Advisor: Nancy Stanwood M.D., M.P.H. Yale Family Planning Fellowship Director

Project: A pilot study to develop and evaluate a group prenatal contraception counseling model to improve postpartum contraceptive care

Project Responsibilities: Designed research protocol, supervision of research staff for participant recruitment and follow-up, will conduct focus groups, and will do primary quantitative and qualitative data and analysis, and manuscript writing.

7/2013-5/2014 **Indiana University, Department of Obstetrics and Gynecology, Indianapolis, IN**

Role: Primary Researcher

Advisor: John Stutsman, M.D., IU Faculty and Medical Director of Planned Parenthood

Project: Impact of immediate postpartum contraception on rapid repeat pregnancy and abortion in postpartum adolescents

Project Responsibilities: Designed and implemented research protocol, completed data collection and input, and data analysis with assistance from the department's statistician.

6/2008-8/2008 **Innovations for Poverty Action, La Paz, Bolivia**

Role: Internship

Advisor: Judy Lewis, Ph.D. and Doug Parkerson, Director of Project Development

Project: A descriptive study of participants' utilization of specific health care resources.

Project Responsibilities: Worked with the CRECER-Saludable on their health credit marketing study to research use of community health loan applications and outreach techniques; compiled a database of health fairs, health services and health loan clients.

7/2004-8/2004 **Cross-Cultural Solutions, Ayacucho, Peru**

Role: Independent Student Researcher/Clinic Volunteer

Advisor: Felicity Northcott, Ph.D.

Project: A qualitative study exploring the interplay between traditional and modern medicine in Ayacucho, Peru.

Project Responsibilities: Interviewed local physicians, traditional healers, and herbal vendors regarding prescribing practices, access to therapies, and public perception.

Clinical Responsibilities: Patient intake, and observing deliveries and clinic visits.

1/2004-5/2004 **Johns Hopkins University, Department of Anthropology, Baltimore, MD**

Role: Student Researcher

Advisor: Pamela Reynolds, Ph.D.

Project: Analyzed the use of prenatal care services of Hispanic mothers, adolescent mothers, and mothers of other minority groups in order to identify factors preventing mothers from accessing prenatal care.

Project Responsibilities: Used ethnographic research methods, transcribed Spanish interviews into English for analysis, coded data, and performed thematic analysis to determine barriers to prenatal care for Hispanic women.

Publications

Qasba, N. A., Shamshirsaz, A. A., Feder, H. M., Campbell, W. A., Egan, J. F., & Shamshirsaz, A. A. (2011). A case report of human granulocytic anaplasmosis (ehrlichiosis) in pregnancy and a literature review of tick-borne diseases in the United States during pregnancy. *Obstetrical and Gynecological Survey*, 66(12), 788-796. doi: 10.1097/OGX.0bo13e31823e0d0e.

Poster Presentations

- Qasba, N., Stutsman, J., Weaver, G., Weber, K., Daggy, J.** (2014, October). Impact of immediate postpartum contraception on the rate of rapid pregnancy in adolescents in an urban hospital system. Poster presented to the American College of Obstetricians and Gynecologists Annual District Meeting, Indianapolis, IN.
- Qasba, N., Shamsihsaz, A. A., Feder, H. M., Campbell, W. A., Egan, J. F., & Shamsihsaz, A. A.** (2011, August). Human granulocytic anaplasmosis (ehrlichiosis): Case report and literature review of tick-borne diseases during pregnancy. Poster presented to the Society of Infectious Diseases in Obstetrics and Gynecology, Chicago, IL.
- Magidina, I., Qasba, N., & Johnson, A.** (2011, May). Will the new ACOG recommendations delay the onset of Pap smear screening until age 21 increase the number of individuals in their early 20's with clinically significant cervical disease (CIN II or greater)? Poster presented to the University of Connecticut School of Medicine Department of Obstetrics and Gynecology, Farmington, CT.
- Qasba, N., Pfeiffer, C., Armstrong, P., Hinz E., Gutierrez, J., & Robinson, R.** (2011, October). Interactive medical Spanish curriculum for medical students in clinical settings. Poster presented to the American Academy for Communication in Health Care, Phoenix, AZ.
- Qasba, N.,** (2010, February). Cross-sectional study of female participants in micro-credit-funded health fairs in La Paz, Bolivia. Poster presented to the University of Connecticut School of Medicine, Farmington, CT.

Oral Presentations

- Qasba, N.** (2016, April). Immediate Postpartum LARC: From Research to Policy to Practice. Presentation at the ACOG Indiana Section Meeting.
- Qasba, N., Stutsman, J., Weaver, G., Weber, K., Daggy, J., Miller, V.** (2014, November). Rapid Repeat Pregnancies and Birth Spacing in Adolescents. Presentation at the Labor of Love Summit. Helping Indiana Reduce Infant Mortality. Indiana State Department of Health

Grants

- 2016 **Society of Family Planning Research Award, Yale University, New Haven, CT (\$99,805)**
Role: Primary Investigator
Advisor: Nancy Stanwood M.D., M.P.H. Yale Family Planning Fellowship Director
Project: A pilot study to develop and evaluate a group prenatal contraception counseling model to improve postpartum contraceptive care
Project Responsibilities: Designed research protocol, supervision of research staff for participant recruitment and follow-up, will conduct focus groups, and will do primary quantitative and qualitative data and analysis, and manuscript writing.
- 2009-2011 **Kaiser Permanente Curriculum Grant, University of Connecticut School of Medicine, Farmington, CT (\$3,500)**
Role: Volunteer Coordinator for Advanced Medical Spanish Program.
Adviser: Carol Pfeiffer, Ph.D.
Project: Advanced Medical Spanish Course for UConn medical students
Project Responsibilities: Designed and implemented a Spanish language program including lectures for Spanish-speaking medical students by bilingual clinicians focused on medical interviewing on diabetes, hypertension, obstetrics and gynecology, pediatrics and depression. Also helped write standardized clinical encounters patient cases and trained bilingual instructors so students could practice clinical histories in Spanish.

- 2006-2007 **Connecticut Health Foundation Racial and Ethnic Health Disparities Grant**, Charlotte Hungerford Hospital, Torrington, CT (\$40,000)
Role: Grant Writer
Project Manager: Marty Mancuso, Ph.D.
Project: Improving Language Access and Culturally Competency Services for Latino Community in Litchfield County.
Project Responsibilities: Wrote the grant proposal to address ethnic/racial health disparities in Northwest Connecticut which included formal training of hospital medical interpreters, culture competency training, and bilingual signs and consents.
- 2007-2010 **University of Connecticut Human Rights Institute 'Ideas Into Action' Grant**, University of Connecticut School of Medicine, Farmington, CT (\$1,000)
Role: Grant Writer, Organization Leader
Adviser: Judy Lewis, Ph.D.
Project: The Global Health and Human Rights Film Series
Project Responsibilities: Organized a monthly film and lectures series that featured documentary films and panelists regarding current themes in global human rights and health.

University, Department and Professional Service

- 01/2013-9/2014 **District V Junior Fellow Advocacy Chair**, American College of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis, IN
- Coordinated and organized legislative activities and lobby days promoting women's health and ACOG-supported policies in district V.
 - Attended Indiana Perinatal Network Neonatal Abstinence Syndrome Symposium (2014) and spoke with the State Atty. General regarding ACOG policies and guidelines on substance use treatment in pregnancy.
 - Attended the ACOG Congressional Advocacy Leadership Program in Washington, D.C. and visited Indiana Senate and House representatives to lobby for women's health programs and initiatives (March 2013 and March 2014)
 - Guest speaker on Telemundo-Indiana Spanish television (2014) – discussed importance of prenatal care for the Hispanic community
 - Participated in the annual ACOG-Indiana Section Legislative Advocacy Task Force Retreat to support access to contraception and women's health services (2013, June)
- 08/2011-6/2015 **Coordinator, Indiana University Family Planning Interest Group**, Indiana University School of Medicine, Indianapolis, IN
- Organized a multi-disciplinary email network of university faculty, nurses, lawyers, residents, and students interested in reproductive health issues
 - Assisted in the establishment of the Medical Students for Choice chapter at Indiana University School of Medicine
 - Organized advocacy events at Indiana University School of Medicine in collaboration with Indiana University Robert H. McKinney School of Law as well as with community organizations. Some of these events included the Bei Bei Shau trial, law panel on state reproductive health laws and debates, and a talk by Lynn Paltrow from the National Advocates for Pregnant Women for the resident body.
 - Guest speaker (2013) – Organized education session on contraception for pregnant mothers' support group receiving treatment at the Midtown methadone clinic
 - Guest speaker for the National Center for Excellence *Women of Influence* event (2013) – discussed current legislative issues regarding women's health in Indiana
 - Guest speaker for Physicians for Human Rights (2012) – discussed access to reproductive health services in the context of basic human rights

University, Department and Professional Service (cont.)

08/2009-08/2011 **Member, Medical Students For Choice**, University of Connecticut School of Medicine Farmington, CT

- Helped coordinate events including contraception education night for medical students hosted by residents
- Organized an event called "What is Choice?" featuring a multi-disciplinary panel of OBGYN providers and clergy members discussing patient stories and various clinical scenarios to highlight the need for access to abortion.

08/2009-08/2010 **Co-Chair, OBGYN Scholars**, University of Connecticut School of Medicine Farmington, CT

- Coordinated monthly student interest group meetings on topics related to women's health/obstetrics and gynecology including case presentations, journal clubs, simulation and laparoscopic practice sessions, subspecialty night and preparation for residency interviewing and residency in general.

08/2008-08/2009 **Co-President, International Medical Practice and Exchange (IMPAX)**, University of Connecticut School of Medicine, Farmington, CT

- Organized monthly Lunch and Learn series featuring faculty with international health projects
- Coordinated the Medical Mission Lecture Series featuring doctors who participated in medical missions abroad, including Gaza, Pakistan, and Bolivia

08/2005-08/2005 **Coordinator, Programa Salud**, Johns Hopkins University, Baltimore, MD

- Coordinated four major projects including Health Education for Children and Adults, Medical Interpretation, Annual Health Fair, and Cultural Competency Workshops
- Organized and secured funding for medical interpretation training for ten bilingual undergraduate clinical volunteers
- Collaborated with Baltimore City Immigrant Support and Outreach Center in Volunteer Interpreter Corps Initiative
- Volunteered over 100 hours of medical interpreting in Baltimore City Family Planning Clinic and Caroline Street Free Health Clinic
- Organized our Annual Leadership Conference *Changing The Face of Health: Addressing Diversity and Disparities in Health Care*

Employment Experience

6/2007-1/2011 **English-Spanish Translator**
TRIPP Center, University of Connecticut Health Center, Farmington, CT

- *Responsibilities:* Translated documents for study evaluations and surveys, interviews, consent forms, and assessment surveys for community health program evaluations

5/2007-8/2007 **Outreach/Case Worker for Migrant Farm Worker Program**
Hispanic Health Council, Hartford, CT

- *Responsibilities:* Conducted outreach activities and health education for farm workers and their families; provided case management, appointment scheduling and medical interpretation services

6/2006-5/2007 **Cultural Liaison/Medical Interpreter**
Charlotte Hungerford Hospital, Torrington, CT

- *Responsibilities:* Served on the hospital's Diversity Committee to review and evaluate the needs for language services for the expanding diversity in the patient population; provided medical interpretation

Certification and Licensure

Connecticut Medical Licensing Board (2014 – present)

Physician

License No. 53717

Indiana Medical Licensing Board (2011 – 2015)

Resident Physician

License No. 11015991A

Certified Bilingual Staff Level Proficiency in Spanish, Pacific Interpreters Language Proficiency Test (2007)

Certified Medical Interpreter, Completed *Bridging the Gap* training in May 2005

Professional Memberships

American College of Obstetrics and Gynecology, Junior Fellow (2011-present)

Physicians for Reproductive Health (2013-present)

Society of Family Planning (2015-present)

Association of Reproductive Health Professionals (2015-present)

American Institute for Ultrasound in Medicine (2015-present)

National Abortion Federation (2015-present)

PRINT NAME:

Neena Qasba

DATE:

3/20/2017

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS

YES NO

1. While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)
- 2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?
- 2-B. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?
5. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?
6. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)
7. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?
- 8-A. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?
- 8-B. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)

PRINT NAME:

Neena Dasba

DATE:

3/30/2017

YES NO

- 9-A. Have you ever relinquished any medical staff membership or association with a health care facility?
- 9-B. Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?
- 9-C. Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?
10. Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)
11. Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?
13. Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?
- 14-A. Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?
- 14-B. Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?

PRINT NAME:

Neena Gasba

DATE:

3/30/17

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

YES NO

15. Do you have a medical or physical condition that currently impairs your ability to practice medicine?
16. Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?
17. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME:

Neena Wasba

DATE:

3, 30, 17

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (Note: Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (Note: This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

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

Applicant's Signature:

Neena Wasba

Date:

3, 30, 2017

Sealed Envelope

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

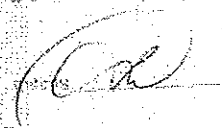
<p>PHOTOGRAPH</p>	<p>CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER</p>
<p>_____</p>	<p>This certifies that I have been personally acquainted with the physician named below:</p>
<p>_____</p>	<p>_____ <u>Neena Qasba</u> _____ (name of applicant)</p>
<p>_____</p>	<p>for <u>2</u> years. I believe that 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.</p>
<p><u>Neena Qasba</u> Signature of applicant</p>	<p><u>[Signature]</u> Signature of Certifying Physician</p>
<p>I certify that the photograph above is a genuine likeness of the maker of the signature above.</p>	<p><u>1-054166</u> <u>CT</u> License Number. State</p>
<p><u>Patricia M. Johnson</u> Signature of Notary</p>	<p><u>ERICA F ROBINSON</u> Type or print name clearly</p>
<p><u>02/28/2019</u> My commission expires</p>	<p>Address: <u>330 Cedar St</u> <u>FMB 339</u></p>
<p>_____</p>	<p>City: <u>New Haven</u> State: <u>CT</u> Zip: <u>06520-8063</u></p>
<p>_____</p>	<p>Telephone: <u>(203) 785-5545</u> Date: <u>3/13/17</u></p>

Seal Verifier's
DATE: _____
INITIALS: HR/LJ

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

Sealed Envelope

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



MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

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

Applicant's Signature: Neena Gasba Date of Birth: _____

Name (Please type or print): Gasba Neena T
(Last Name) (First Name) (Middle Initial)

Other Name(s) (Please type or print): N/A

Name of Medical School: University of Connecticut

Address: 263 Farmington Ave. City: Farmington State or Province: CT

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: JOHNS HOPKINS UNIVERSITY

Undergraduate School Address: BALTIMORE, MD

Enrollment and Participation:

Our records indicate that QASBA XNEWA T
(Print the applicant's name) (Last name) (First name) (Middle Initial)

attended our medical school for a total of 104 weeks (must be included) of continuous medical education on the following dates from 08/17/2007 to 05/15/2011
month/day/year month/day/year

This applicant:

Check one: was awarded the degree of DOCTOR OF MEDICINE on 05/15/2011
month/day/year
 will be awarded the degree of _____ on 1/1/
(Form B must also be completed and returned directly to the Board.) month/day/year
 was not awarded a degree because: _____

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

- | | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Was the medical school training more than <u>four (4) years</u> for U.S. graduates or <u>6 years</u> for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"? | | |
| 2. Was the applicant ever placed on probation or remediation? | | |
| 3. Was the applicant ever disciplined or under investigation? | | |
| 4. Were any negative reports ever filed by instructors regarding the applicant? | | |

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

AFFIX INSTITUTIONAL SEAL HERE

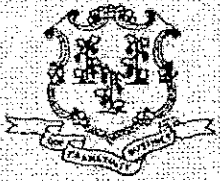
(If the institution does not have a seal, this form must be notarized.)

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

Signature: [Signature]
Print Name: ROBIN FRANK PRODEGAN
Title: DIRECTOR STUDENT SERVICES
Date: 5/31/17 Telephone: (810) 679-8765
E-mail address: frank@wchc.edu

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

Seal Verified
DATE: 4/6/17
INITIALS: [Signature]



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

March 23, 2017

Sealed Envelope

RECEIVED
Board of Registration in Medicine
MAR 27 2017

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

[Handwritten signature]

TO WHOM IT MAY CONCERN:

VERIFICATION OF LICENSURE

This is to certify that the records of the Connecticut Department of Public Health indicate that:

NEENA QASBA, MD

Was issued Connecticut: Physician/Surgeon License
Date of Issuance: 11/26/2014
License Number: 53717
Expiration Date: 02/28/2018
Status of License: ACTIVE, CURRENT
Past or Pending Disciplinary History: No

Disciplinary History

Past or pending public disciplinary action:

There has been no public disciplinary action Public action taken, see attached X

Past or pending confidential action taken:

There has been no confidential disciplinary action Complaint under investigation, see attached Confidential action taken, see attached Other, see attached X

Sincerely,

[Handwritten signature: Stephen B. Carragher]

Stephen B. Carragher
Public Health Services Manager
Practitioner Licensing and Investigations Section

Printed by: Angela Holmes



Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Sealed Envelope

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [Handwritten Signature] Date: 2/28/17
Print or Type Name: Neena Qasba
Name and Address of Institution: Indiana University
550 University Blvd.
Indianapolis, IN 46202

TO BE COMPLETED BY PROGRAM DIRECTOR

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

Name of Institution: Indiana University
Name of Institution, if different when applicant attended: _____
Verification for: Neena Qasba
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year)		Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
			FROM	TO		
Internship	1	Obstetrics & Gynecology	7/1/11	6/30/12	Y	ACGME
Residency	2-4	Obstetrics & Gynecology	7/1/12	6/30/15	Y	ACGME
			1 1	1 1		
			1 1	1 1		
			1 1	1 1		

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

APPLICANT'S NAME: Neena Qasba

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

QUESTIONS

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?

COMMENTS: _____

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

**AFFIX
INSTITUTIONAL
SEAL HERE**

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

Program Director's Signature: [Signature]
Print Name: Anthony Shanks, M.D.
Academic Title: Residency Program Director
Telephone: 317.948.5923 Today's Date: 3/2/17
E-mail address: cbrespgm@iupui.edu

Venus A. Davis-Wallace
Seal
Notary Public - State of Indiana
Marion County
My Commission Expires Jan 1, 2024

Venus A. Davis-Wallace
Notarized in witness
Here of on
March (3) 2, 2017

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

Seal Verified
DATE: 4/6/17
INITIALS: [Signature]

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: Neena Qasba Date: 2-28-17
 Print or Type Name: Neena Qasba
 Name and Address of Institution: Yale University
310 Cedar St, FMB 320
New Haven, CT 06519

TO BE COMPLETED BY PROGRAM DIRECTOR

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

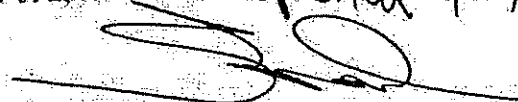
Name of Institution: Yale University

Name of Institution, if different when applicant attended: _____

Verification for: Neena Qasba
 (Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year)		Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
			FROM	TO		
1. Fellow	PGY 5	Family Planning Fellowship	07/01/15	6/30/16	In progress	not accredited
2. "	PGY 6	"	7/1/16	6/30/17	In progress	"
			1/1	1/1		
			1/1	1/1		
			1/1	1/1		

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

updated 6/2/17


APPLICANT'S NAME: Neena Qasba

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

QUESTIONS YES NO


1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?

COMMENTS: _____

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

**AFFIX
INSTITUTIONAL
SEAL HERE**

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

Program Director's Signature: 
Print Name: Nancy L. Stimmord
Academic Title: Assistant Professor
Telephone: (203) 737-4665 Today's Date: 3/22/17
E-mail address: Nancy.Stimmord@yale.edu

Patricia M. From - 3/22/17

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

Page 1 updated 6/2/17

Seal Verified
DATE: 4/6/17
INITIALS: (S)

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

Sealed Envelope

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: Neena Dasba Date: 2/28/17

Please PRINT your name: Neena Dasba

Name of facility: Gale New Haven Hospital State: CT

INSTRUCTIONS TO THE CHIEF OF SERVICE, PROGRAM DIRECTOR OR SUPERVISOR, WHO MUST BE A PHYSICIAN: Please complete items #1-7 below and return to the applicant with your name affixed across the envelope seal.

1. How long have you worked with the applicant? From: 07/15/15 To: present

A. In what capacity? supervisory other: _____

B. Date(s) of applicant's affiliation at facility: From: 07/15/15 To: 6/30/17

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

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

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

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

(Continued on page 2)

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

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

Dr. Dasba is a professional and conscientious physician. She is safe and would be a valuable asset.


6. The above comments are based on the following:

- Close personal observation
- General impression
- A composite of previous evaluations by other physicians
- Other _____

7. **RECOMMENDATIONS:**

- Recommend for licensure in Massachusetts.
- Recommend for licensure in Massachusetts, with the following reservations: _____

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

Signature:  (check one) M.D. or D.O.

Print Your Name: ERICA F ROBINSON Date: 3/3/17

Academic title or position: Assistant Professor Phone number: 203-500-2934

Specialty/Service or Department: Dept of ObGyn + Reproductive Science, Yale University

E-mail address: erica.robinson@yale.edu

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