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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

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

Registration No.: 58266 Renewal Date: 03/27/1999 1. Current Status: Active

RECEIVED APR 6 1999 Board of Registration in Medicine

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

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

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

Please make corrections (type or print)

Other Name(s): _____

3. A) Mailing/Home Address:
CHRISTINE MARIE BOULANGER, M.D.

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

B) Business Address:

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

Home Phone:
Business Phone: (617)492-3500

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

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

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

5. A) Name of Medical School:
University of Vermont College of Medicine
B) Year Graduated: 1982 C) Degree: MD

Full Name of Medical School: _____

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

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

Code(s)	Hours per Week in Mass.	
OBG	80	Obstetrics and Gynecology

Code(s)	Hours Per Week in Massachusetts
_____	_____
_____	_____
If OS, Print Specialty:	_____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

Abbr: _____
Abbr: N H C A

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

♻

PRINT NAME AND NUMBER: Last Name: BOLANGER Registration Number: 58266

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

Facility Code: 211 (AP) 10 % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %

Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %

If 999, print name(s): _____

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

Name of Insurer: Controlled Risk Insurance Co. of Vermont, Inc. Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Christine M. Bolanger MD Date: 3/21/07

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

PRINT NAME AND NUMBER: Last Name: BOULANGER Registration Number: 58266

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

IN THE PAST TWO (2) YEARS: **YES NO**

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Christine M. Boulanger MD Date: 4/3/19

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

♻

check # 3112861
rec. 4-21-97

CIGNA HealthCare

REQUEST FOR MEDICAL LICENSE/LICENSE RENEWAL FORM
(Please print legibly or type)

Name of Licensee: Christine Boulanger, MD

Date of Birth: _____

License Number: 582616

I hereby authorize the Board of Registration in Medicine to make a photocopy of my most recent medical license application or renewal form, including all attachments and other explanatory materials, and to send the photocopy to the following address:

CIGNA Health Care
20 Speen Street, 3rd Floor
Framingham, MA 01701-4680

Signed: _____

Date: 3/17/97

Y:\userdata\formlets\rml

THE RITZ-CARLTON

check #1513
rec. 4-29-97

4/23/97

Dear Board of Registration in Medicine,

Please send me a ~~copy~~ of my application for registration renewal for 1997-99. Thank-you.

Sincerely,

Christine M. Baubegas MD

DoB

License # 58266

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

Registration No.: 58266 Renewal Date: 03/27/97

RECEIVED ELN 3/12/97 BOARD OF REGISTRATION IN MEDICINE

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

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

Corrections (type or print)

Other Name(s): _____

3. A) Mailing/Home Address:

CHRISTINE MARIE BOULANGER, M.D.

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

B) Business Address:
22 MILL ST.
ARLINGTON, MA 02174

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

Home Phone:
Business Phone: (617)492-3500

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

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 08/01/87 D) SS#:

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

5. A) Name of Medical School:

University of Vermont College of Medicine
B) Year Graduated: 82 C) Degree: MD

Full Name of Medical School: _____

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

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

Code(s)	Hours per Week in Mass.	
OBG	80	Obstetrics and Gynecology

Code(s)	Hours Per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, Print Specialty: _____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

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

LLS

PRINT NAME AND NUMBER: Last Name: BOULANGER Registration Number: 58266

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

Facility Code: 411 /✓ (AP) Facility Code: ___ / (AP) Facility Code: ___ / (AP)
Facility Code: 432 /✓ (AP) Facility Code: ___ / (AP) Facility Code: ___ / (AP)
If 999, print name(s): _____

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

Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write Name(s): _____

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

Name of Insurer: Controlled Risk Insurance Company of Vermont, Inc.

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

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

Please explain exemption: _____

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

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

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

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

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

PART A

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

IN THE PAST TWO (2) YEARS:

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

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

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

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

Signature Christine M. Boulanger MD Date: 2 / 8 / 17

PRINT NAME AND NUMBER: Last Name: BOULANGER Registration Number: 58266

PART B CONFIDENTIAL MEDICAL INFORMATION

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

IN THE PAST TWO (2) YEARS	YES	NO

23. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?

24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine?

Treating Organization: _____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

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

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

Signature Christine M. Boulanger MD Date: 2/8/17

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

Registration No.	Status	Fee	Renewal Date	Late Fee
58266	ACTIVE	$250.00	03/27/95	$25.00

Mailing Address:

CHRISTINE MARIE BOULANGER, M.D.
ANDOVER OB/GYN P.C.
140 HAVERHILL STREET
ANDOVER, MA 01810

Correction of Mailing Address

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

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

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

For Office Use Only
M.R. _____
Pt. _____
Bk/D.E. _____

Pre-Printed Information

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

2. Home Address:

3. Date of Birth: Sex: F
   Lic. Issue Date: 08/01/87 SS#:

   Home Phone: ( ) -
   Business Phone: (508) 475-3502

4. Name of Medical School:
   University of Vermont College of Medicine
   Year Graduated: 82 Degree: MD

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

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

Code	Hours per Week in Mass.
OBG	0

Obstetrics and Gynecology

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

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

Corrections of Pre-Printed Information

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

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

Home: _____ Business: (617) 492 3500

Full Name of Medical School: _____

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

CA
NH

Code	Hours per Week in Mass.
	80

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: BOULANGER Registration Number: 58266

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

Facility Code: 071 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

Facility Code: 099 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

11. My medical malpractice insurance is covered by (a) Insurance Carrier ✓ (b) Letter of Credit ___ If applicable, check one.

List Insurer: CRICO RISK MANAGEMENT FOUNDATION

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

State how otherwise exempt: ___

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

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

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 30 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 40 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 100 %

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

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

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

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

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

Signature: Christine M. Boulanger MD Date: 2/8/95

TUFTS ASSOCIATED HEALTH PLANS

The Managed Care Company

RELEASE FORM

In compliance with the Board of Registration in Medicine's (BORM) credentialing regulations, 243 CMR 3.00, TAHP and THP request that you sign the following release:

I hereby authorize:

A. My primary hospital to release to Tufts Associated Health Maintenance Organization, Inc.(TAHP) and Total Health Plan, Inc. (THP) any credentialing information in which I have an interest which may be requested by TAHP/THP: and

B. The Massachusetts Board of Registration in Medicine (BORM) to release to TAHP/THP my applications for initial or renewal registration when requested by TAHP/THP.

Boulanger

Christine M. Boulanger MD
PHYSICIAN'S NAME (please print)

58266
PHYSICIAN'S LICENSE #

Christine Boulanger MD
PHYSICIAN'S SIGNATURE

DATE: 5/1/95

PRIMARY HOSPITAL AFFILIATION: Mt. Auburn Hospital.

Tufts Associated Health Plans, Inc.
333 Wyman Street
P.O. Box 9112
Waltham, Massachusetts 02254-9112
(617) 466-9400 Fax: (617) 466-8583

Tufts Associated Health Maintenance Organization, Inc.

Total Health Plan, Inc.
Preferred Provider Organization

ManagedComp, Inc.
Managed Care Workers' Compensation

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
52260	ACTIVE	$250.00	05/27/93	$25.00

Mailing Address:
CHRISTINE MARIE BOULANGER, M.D.
ANDOVER OB/GYN P.C.
140 HAVERHILL STREET
ANDOVER, MA 01810

Correction of Mailing Address:
Address (Mailing): _____
_____
City/Town: _____
State: _____
Country Code (See Table 1): _____

Directions: Staple check to bottom of form. Add late fee if necessary.
- *Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.*
- Before proceeding, please read the instruction booklet. Some questions are optional.
- ***Make a copy of this form and all attachments for your own records*** *- you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.*
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. RECEIVED FEB 05 1993
Pr. 31
Bk/D.E. 2/5/93 DH

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   ANDOVER OB/GYN P.C.
   140 HAVERHILL STREET
   ANDOVER, MA 01810

3. Date of Birth: Sex: F
   Lic. Issue Date: 08/01/87 SS#:
   Telephone Number:
   Home: ( ) - Business: (508)475-3502

4. Name of Medical School:
   University of Vermont College of Medicine
   Year Graduated: 82 Degree: MD

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

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.	
026	30	Obstetrics and Gynecology

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: 08 Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

8. Drug License Number(s), if any: a) Federal (DEA)
   b) State (MA)

9. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested _____
   You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): _____
City/Town: _____
Country Code: _____ If 999 print Country: _____

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____
Lic. Issue Date (M/D/Y): __/__/__ SS#: _____
Telephone Number:
Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____
Year Graduated: _____ Degree (MD/DO): _____

Code	Hours per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, print specialty: _____

Code: _____ Code: _____
Code: _____ Code: _____
Federal (DEA): _____
State (MA): _____

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Boulanger Registration Number: 56166

10. **Activity Status:** I am applying to be registered with the following status: Active ✓ Inactive ___

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: MA SUA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am
(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___
(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 99 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes___ No ✓ (Check one)

14. a) What is your principal work setting? (See Table 5) 20

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 30 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 40 hrs/wk in MA

Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

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

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

- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: C Boulanger Date: 1/26/93

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1991-1993 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date
43269	ACTIVE	$150	03/27/91

Dr. CHRISTINE MARIE BOULANGER
ANDOVER OB/GYN P.C.
140 HAVERHILL STREET
ANDOVER, MA 01810-

For Office Use Only

M.R.		
Pr.		
Bk.		
Ch.	JR	12/5/91
D.E.		1/28/91

Directions:

- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:

I am applying to be registered with the following status: Active ✓ Inactive ____

I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

   Name: ____

2. a) Address (Home):

   Address: ____
   City/Town ____
   State: ____ Zip: ____
   Country Code: ____ (If 999 write Country): ____

2. b) Address (Business):

   ANDOVER OB/GYN P.C.
   140 HAVERHILL STREET
   ANDOVER, MA 01810-

   Address: ____
   City/Town: ____
   State: ____ Zip: 01810
   Country Code: ____ (if 999, write Country): ____

3. Date of Birth: 03/27/55 Sex: F
   Lic. Issue Date: / / SSN #: - -
   Telephone Number:

   Home: ( ) -
   Business: (508)475-3502

   Date of Birth (M/D/Y): ____ Sex (M/F): ____
   Lic. Issue Date(M/D/Y): 08/__/87 SSN #: 008-42-4315
   Home: ( ) UNLISTED Business: ( ) ____

4. Medical School Code: VT002 Year Graduated: 82 Degree: MD
   Name of School:
   University of Vermont College of Medicine

   School Code: ____ Year Graduated: ____ Degree (MD/DO): ____
   If 99999, write School: ____

5. a) Other States where you are now licensed to practice (*Abbr*): NH CA
   b) States where you previously were licensed to practice (*Abbr*):

   ____ ____ ____ ____ ____ ____
   ____ ____ ____ ____ ____ ____

6. Specialty Code(s) *(See Table 3)*:

Code	Hours per Week in Mass.	
04.6	0	Obstetrics and Gynecology
	0	

Code	Hours per Week in Mass.
____	____
____	____

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:

Code: 06 Board of Obstetrics and Gynecology
Code:

Code: ____
Code: ____

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) ____ b) How many DEA nos. do you have? ____
   c) State (MA) #M ____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES ✓ Waiver Requested ____
   (You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See Instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*

[For Office Use Only: Waiver Granted ____ Date: ____/____/____]

FILL IN NAME AND NUMBER:

Physician Last Name: BOULANGER Registration No.: 58266

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT _____. If applicable, check one.

List Insurer: COA of Massachusetts

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: _____ (ii) OTHERWISE EXEMPT: _____

(State how otherwise exempt): _____

11. Current Hospital Affiliations *(Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).*

Facility Code: 999 /✓(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)

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

If 999, write Name(s): _____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code: 999 Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write Name(s): Redlands Community Hospital Redlands, CA

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No ✓ (Check one.)

b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program?_____hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 30 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 40 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 20

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A. Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?		

Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

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

I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.

Signature: Kristine M. Boulanger MD Date 1/11/11

Commonwealth of Massachusetts Board of Registration in Medicine

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

1989-1991 Physician Registration Renewal Application, Page 1 of 2

00457

Board Use Only:

Registration No.	Status	Fee	Renewal Date
58266	L	$150	03/27/89

CHRISTINE MARIE BOULANGER
ANDOVER OB/GYN P.C.
140 HAVERHILL STREET
ANDOVER, MA 01810

M.R.	KHF	/ /
Pr.	CB	2/3/89
Bk.	CB	2/10/89
Ch.		/ /
D.E.	KQG	3/8/89
Fl.		/ /

Important:

- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--it is not adequate to state that the Board already has the information.*
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) Same as above (FIRST:) (M.I.:)

1. b) *Other Name(s), if any, that you were ever licensed under:*

2. a) Address (Mailing): Same as above

2. b) Address (Home):

2. c) Address (Business): Same as 2a.

2. d) Telephone (Business): (508) 475-3502 Extension none 2. e) Telephone (Home) *(Optional)*: ( ) -

3. Date of Birth (MO/DA/YR): 4. Sex: MALE___ FEMALE ✓ 5. Social Security No. *(Optional)*: -- --

6. a) Medical School Code *(See Table 1)*: VT002 *If 99999, write* Name:

6. b) Year Graduated: 1982 6. c) Degree: M.D. ✓ D.O.___

6. d) Country: U.S. ✓ Canada___ Code if Other *(See Table 2)*: *If 999, write* Name:

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

10 Hospital	%___	15 Private Office	%___	20 Partnership/Group Practice	100 %
25 Clinic	%___	30 Mental Health Center	%___	35 Nursing Home	%___
40 HMO Facility	%___	45 Educational Institution	%___	50 Medical Society	%___
55 Government Facility	%___	60 Plant/Commercial Setting	%___	99 Other	%___

8. Professional Activity *(Circle and Indicate Percent(%) of Professional Time)*:

10 Resident or Fellow	%___	20 Practice Involving Direct Patient Care	100 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): / /
30 Administrative Activities	%___	40 Medical Teaching	%___	
50 Medical Research	%___	99 Other	%___	

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 100 % Specialty Code: ____ Percent of Practice Time: ___%
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) Y *10. b) If YES, circle which Board(s):*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	(OG)	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) *Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. (See Table 4.)*

Facility Code: 099 100 %	Facility Code: ____ ___%	Facility Code: ____ ___%
Facility Code: ____ ___%	Facility Code: ____ ___%	Facility Code: ____ ___%

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write Name(s):

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) ____ attached pages--is true.

Signature: Christine M. Boulanger MD *(See reverse side)* **Date:** 12/30/88

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

Fill in name and number. **Physician Last Name:** Boulanger **Registration No.:** 58266

12. a) Other States where you are now licensed to practice *(Abbreviate)*: NH CA ___ ___ ___ ___

12. b) States where you previously were licensed to practice *(Abbreviate)*: ___ ___ ___ ___ ___ ___

13. I am applying to be registered with the following status: ACTIVE ✓ *INACTIVE ___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 111 hrs., Category II: 30 hrs., (Risk-Management: 10 hrs.); Residency Program in: ___;
Waiver Requested ___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT ___. *If applicable, check one and identify the name.*
Insurer: BIM (MAT) Institution Issuing Letter of Credit: ___
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* ___

14. c) Percent of Practice Time in Massachusetts: 90 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--See Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ___ ___		

Additional Information Related to Questions 18 through 24 *If you answered YES to any of Questions 18--24 provide the following information where applicable.*

Privileges to Prescribe Controlled Substances *Attach additional sheets (with same format) where necessary.*
Type of Restriction: ___ Date: ___/___/___
Circumstances of restriction: ___

Withdrawal or Denial of License *Attach additional sheets (with same format) where necessary.*
State: ___ Year: ___ Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated): ___

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary.*
Treating Organization: ___ Telephone: (___) ___-___
Address: ___
Person Responsible for Treatment: ___
Type of Condition and Treatment: ___
Dates of Illness/Dependency: ___/___/___ to : ___/___/___ Dates of Treatment: ___/___/___ to : ___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary.*
Organization: ___
Date: ___/___/___ Action: ___
Circumstances leading to loss of certification or denial of recertification: ___

AFP 5-7-13-87

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
10 West Street, Boston, MA 02111

Approved:
Disapproved:

Application for Endorsement Registration - NATIONAL BOARDS
(Fee- $150. must accompany APPLICATION - No currency or personal checks)

Filed: 7-14-87
By: K.C.
Form of Fee: M.O.

FOR OFFICE USE

Application # 62930
Certificate # 58266 Date of Issue: 9/2/87

PLEASE TYPE OR PRINT

Name: Christine (First) Marie (Middle) Boulanger (Last)
Date of Birth
Place of Birth
Name on Birth Certificate Christine Marie Boulanger

SWORN STATEMENT

Mailing Address:
Phone #

Pre-medical Education
School McGill University, Montreal, CANADA
Dates Attended Sept. 1973 - June 1977

Medical Education
School University of Vermont College of Medicine
Dates Attended September 1977 - June 1982

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

	Place	Position	Dates
(1)	UCLA Center for the Health Sciences 10883 Le Conte Ave. Los Angeles CA 90024	Internship and Residency - OB/GYN	June 1982 - June 1986
(2)	Redlands Community Hospital 350 Terracina Blvd. Redlands, CA 92373	Active staff - OB/GYN	July 1986 → present.

List all other states where you are or have been licensed: California G051652 (since 1983)
Are you a Diplomate of a Specialty Board? Board eligible in obstetrics & Gynecology (name, if applicable)
(written exam passed 6/86).

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

This section of the application must be completed by the Dean of your medical school. If you have attended more than one medical school, additional verification of medical instruction in the other school will be required.

Date: June 25, 1987 19 ____

I hereby certify that Christine M. Boulanger MD has attended 4 years of instruction of not less than thirty-two weeks in each year in: Burlington, Vermont University of Vermont College of Medicine - class of 1982.
(Name of medical school, location) (started '77 - took 1yr. leave of absence 1979).

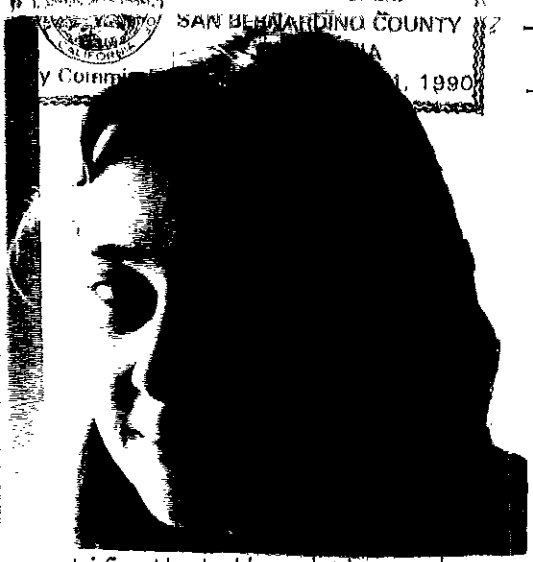
Exact dates of attendance of each year:

From:	Month:	9	Day:	1	Year:	77	To: Month:	6	Day:	17	Year: 78
From:	Month:	9	Day:	7	Year:	78	To: Month:	1	Day:	1	Year: 79
From:	Month:	leave of absence approved				1/1/79	To: Month:	12/31/79	Day:		Year:
From:	Month:	1	Day:	5	Year:	80	To: Month:	6	Day:	30	Year: 80
From:	Month:	7	Day:	1	Year:	80	To: Month:	4	Day:	30	Year: 81
From:	Month:		Day:		Year:		To: Month:		Day:		Year:

AND HAS RECEIVED THE DEGREE OF Doctor of Medicine on May 22, 1982 19 82 from University of Vermont College of Medicine.
(Name of medical school)

David M. Tormey
Signature of Dean
David M. Tormey, M.D., Associate Dean

PAULINE A. PULVER
NOTARY PUBLIC
SAN BERNARDINO COUNTY
CALIFORNIA
My Comm. Expires September 11, 1990
SCHOOL SEAL



I certify that the photograph above is a genuine likeness of the maker of the signature above.
Christine M. Boulanger MD
Pauline A. Pulver
signature of Dean or Notary

PAULINE A. PULVER
NOTARY PUBLIC
SAN BERNARDINO COUNTY
CALIFORNIA
My Comm. Expires September 11, 1990
(expiration date of commission)

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

This certificate must be completed and signed by a physician legally authorized to practice medicine in the United States. The statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts.

Date: 6/22/ 1987

This certifies that I have been personally acquainted with Christine M. Boulanger MD of Redlands, CA. license-CA G051652 for < 1 years; that I believe her to be of good moral and professional character, and in every respect worthy of confidence. I recommend her to the Massachusetts Board of Registration in Medicine.

Michael J. Grossman M.D.
(signature of certifying physician)

Address: 140 Haverhill St., Andover, MA. 01810

License # 48692 State MA.

AFFADAVIT OF APPLICANT

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

Christine M. Boulanger MD. Date: 6/16/87 19 87.
SIGNATURE OF APPLICANT

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

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Christine M. Boulanger MD
PERMANENT ADDRESS: _____

LOCAL MAILING ADDRESS IN (MA): _____

HOSPITAL: Redlands Community Hospital
ADDRESS: 350 Terracina Blvd. Redlands, CA 92373

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.	
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.	
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.	
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.	
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.	
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. California, _____, _____, _____.	18.	☑

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Christine M. Boulanger MD DATE: 6/16/87

(SEE REVERSE SIDE)

BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC SEC NUMBER (OPTIONAL) ___-___-____

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUE TIONS BELOW AND ON THE REVERSE SIDE OF TH APPLICATION. (SEE THE ENCLOSED INSTRUC TIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS THROUGH 24, YOU MUST CHECK THIS BOX ☐
PLEASE USE THE ENCLOSED RETURN ENVELOP

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO.	DA.	YR.	
MD		58266	$100		03	27	87	

NOTE! THIS APPLICATION MUST BE SIGNE AND RETURNED WITH A $100 PA MENT. A CERTIFIED CHECK OR MONE ORDER IS PREFERRED. PERSONA CHECKS ARE ACCEPTABLE.

PAYABLE TO:
COMMONWEALTH OF
MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

CHRISTINE Marie Boulanger, M.D.

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: Same
2. Date of Birth: ___ (MONTH) ___ (DAY) ___ (YEAR)
3. Medical School: UNIV. OF VERMONT College of Medicine - USA M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: USA
5. Date of Graduation: 5/22/82
6. American Specialty Board Certified? ☐ (Check if yes.)
   Which Boards? ___
7. Principal Specialty(ies): ___
8. Principal work setting: ___
9. Home address: ___
10. Principal business address: ___
11. List all hospitals at which you have currently effective privileges: ___
12. List all hospitals at which you have held privileges in the past 20 years: ___
13. States other than Massachusetts in which you are presently licensed to practice: ___
14. List any other states where you were previously licensed to practice: ___

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental *authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)*?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. *Are you now, or have you been in the past, dependent upon alcohol or drugs?*		
23. Have you ever, for any reason, lost American Specialty Board Certification?		
24. *Have you been denied recertification by one or more specialty boards?* If yes, which one(s)? ___		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: ___
26. I am an active ☐ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

___
SIGNATURE

DATE: ___

(See Reverse Side)

McGill University

Montreal, 30th June , *19* 87

I hereby certify that Christine Marie Boulanger

is a graduate of McGill University the degree of Bachelor of Science, with Major in Biology and Great Distinction, having been conferred on June 8th, 1977. Ms. Boulanger completed courses in Biology, Chemistry, Physics and Psychology during the four year degree program.

Pamela Brook
Administrative Assistant
Registrar's Office.

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Medical Board requires this form to be completed by each state wherein I hold ever held licensure. This is your authority to release any information in s, favorable or otherwise, direct to the Board of Registration in Medicine Street, Boston, Massachusetts 02111. Your early response is appreciated. must come directly from the state licensing board.

Christine M. Boulanger MD

Some states charge a fee for this service. We suggest that you call the different states in which you are licensed before you mail this form.

Christine M. Boulanger MD M.D.
(signature)

NAME: Christine M. Boulanger MD

ADDRESS:

My license number is: G051652

AUG 1987 RECEIVED

(DO NOT DETACH)

State of: California

Full Name of Licensee: Christine Marie Boulanger MD

Graduate of: U.C.L.A. Center for Health Science (OB/GYN Residency)
University of Vermont College of Medicine.

License No.: G051652 Issued date: 11/21/83

By: Endorsement/Reciprocity with

BY: NATIONAL BOARD EXAM XXXXXXX

By: Your State Board's Written Examination

License is current? Yes If NO, Why Not?

Has license been suspended or revoked? If YES; Why?

Has licentiate ever been on probation? If YES, Why?

Has license ever been requested to appear before your Board?

If YES, Why?

Derogatory information, if any

Comments, if any

Signed: Lori Garrett
LORI GARRETT

Title: Endorsement Specialist

BOARD SEAL

State Board: California

Date: August 10, 1987

PLEASE MAIL THE RESPONSE TO THE FOLLOWING ADDRESS:

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

ATTN: LICENSING UNIT

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

617/727-3086

To all Applicants

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

I, Christine M. Boulanger MD,
Name

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

Date: 6/16/87

Christine M. Boulanger MD
Signature

Social Security Number, Optiona

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

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

Date: 6/16/87

Christine M. Boulanger MD
Signature

July 28, 1987

Dear Sir or Madame,

I submitted an application for a license to practice Medicine in Massachusetts approximately 6 weeks ago. Please advise me if you have received all of the documentation supporting my application, or what is still needed. I am supposed to start my new job in private practice in Andover, Mass. on September 15, and I certainly hope to have my Massachusetts Medical license before then. Call me any time at [illegible] (leave message). Thank-you.

Sincerely,

Christine M. Landangi MD

BEAVER
MEDICAL CLINIC

2 West Fern Avenue
Redlands, California 92373
(714) ~~793-3311~~
798-6640

6/16/87

Torchon it may concern. The
remainder of my application
as well as National
Board Confirmation and
References are all
coming soon to you under
separate cover.

Enclosed is a money order
for $60.00, for my
Pennsylvania medical license.

I thank you for your patience.

Christine M. Boulanger M.D.

I. PHYSICIAN INFORMATION

CHRISTINE MARIE		BOULANGER	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 58266
License Status Active

First Issue Date 08/01/87

Hospital Affiliation

Mount Auburn Hospital

22 Mill St.
Arlington, MA 02174
U.S.A.
(617) 492-3500

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

~~NH~~
CA

(Please correct as necessary)

Accepting New Patients? ☐ Yes ☐ No

Accept Medicaid? ☐ Yes ☐ No

II. EDUCATION & TRAINING

University of Vermont College of Medicine	MD	82
Medical School	*Degree*	*Date*

Make corrections here

Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint .....

.....

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. BOULANGER

Date	Amount Paid 0.0000	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Note: Please return the survey in the enclosed envelope to:

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

September 1, 1994

Christine Marie Boulanger, M.D.
Andover OB/GYN P.C.
140 Haverhill Street
Andover, MA 01810

Re:
Docket Number 92-156

Dear Dr. Boulanger:

The Complaint Committee of the Board met on August 31, 1994, and discussed the above mentioned complaint. The Committee decided a Letter of Advice would appropriately address the issue raised by Ms. Boulanger.

The Committee agreed with the reviewing physician who believed that better evaluation of Ms. l 's dysmenorrhea was your responsibility. The reviewer stated that persistent and unresponsive dysmenorrhea should have raised suspicion of chronic pelvic pain. She cited ACOG's standards which state that when a patient has persistently painful menses, "endometriosis must be a particular consideration since it can mimic primary dysmenorrhea very closely. Laparoscopy may be indicated for patients who do not respond to drug therapy after 6-12 months."

The Committee also determined that no further action is warranted, and dismissed the complaint. Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please feel free to call me at (617) 727-1788, extension 375, or to write to me at the above address.

Sincerely,

Deirdre K. Manning
Consumer Protection Officer

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

September 1, 1994

Re: Christine Marie Boulanger, M.D.
Complaint No. 92-156

Dear Ms. :

The Complaint Committee of the Board of Registration in Medicine has carefully considered the information you furnished regarding your complaint against Dr. Boulanger. A copy of your complaint was sent to Dr. Boulanger, who was required to respond in writing to the Board regarding the issues you raised. An expert, retained by the Board, also reviewed your complaint and medical records.

After a thorough review of the evidence, the Committee determined that your complaint, and Dr. Boulanger's response should be placed in her permanent record and that a Letter of Advice should be sent to Dr. Boulanger regarding the American College of Obstetrics and Gynecology's standards on treating dysmenorrhea. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions or additional material which you wish the Board to consider, please write to Mary McGonagle, Consumer Protection Coordinator, at the above address. Thank you again for your concern.

Sincerely,

Deirdre K. Manning
Consumer Protection Officer

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

May 4, 1994

Dear Ms. :

I sent you a letter on April 4, 1994, requesting that you sign a medical records release so that I may investigate your complaint against Christine Boulanger, M.D. I have enclosed a copy and another release. Please sign and date the release and return it to me.

I will be on vacation from May 16 to June 6, 1994 and I would like to at least send for your records before I go away. Please call me at (617) 727-1788, Ext. 375, if you have any questions. Thank you for your patience and assistance.

Sincerely,

Deirdre K. Manning
Consumer Protection Officer

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

PAUL G. GITLIN, J.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 4, 1994

Dear Ms.

The Board has recently hired new investigators, including me, and is attempting to investigate the backlog of cases. I apologize for the delay in acting on your complaint. Since I have been assigned to your case, I would like to request your medical records from Dr. . I have enclosed a release. Please sign and date the release and return it to me.

Please call me at (617) 727-1788, Ext. 375, if you have any questions. Thank you for your patience and assistance.

Sincerely,

Deirdre K. Manning
Consumer Protection Officer

(1)

ANDOVER OBSTETRICS & GYNECOLOGY, P.C.

140 HAVERHILL STREET
DOCTOR'S PARK
ANDOVER, MASSACHUSETTS 01810

INFORMATION & APPOINTMENTS
(508) 475-2731
BUSINESS OFFICE
(508) 475-2312

WILLIAM H. CAVERLY, M.D. GYNECOLOGY
ROBERT H. SHANNON, M.D. OBSTETRICS & GYNECOLOGY
MICHAEL J. GROSSMAN, M.D. OBSTETRICS & GYNECOLOGY
CHRISTINE M. BOULANGER, M.D. OBSTETRICS & GYNECOLOGY

6/22/92

Dear Board of Registration in Medicine,

In response to your letter of June 10, 1992, I have enclosed my office records on [redacted] in their entirety. As you can see from perusing these clinical notes, [redacted] made reference to having cramps with her menstrual periods only twice. Dysmenorrhea, as I'm sure you are aware, is an extremely common problem and can be treated with oral contraceptives and/or ibuprofen medications (both of which [redacted] received.). I do not recall any instance in which she described chronic pelvic pain. As you also know, follicular (functional) cysts of the ovaries are a monthly occurrence in young healthy women, and can be 1-7 cm in diameter or even larger. It sounds like [redacted] had a negative experience on the phone with my office staff and I apologize for that, but her history and physical exam were not suggestive of a persistent, slowly enlarging cyst at all. In fact, I would like

↳

ANDOVER OBSTETRICS & GYNECOLOGY, P.C.

140 HAVERHILL STREET
DOCTOR'S PARK
ANDOVER, MASSACHUSETTS 01810

INFORMATION & APPOINTMENTS
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MICHAEL J. GROSSMAN, M.D. OBSTETRICS & GYNECOLOGY
CHRISTINE M. BOULANGER, M.D. OBSTETRICS & GYNECOLOGY

(2)

to see the pathology report of the cyst which she had surgically removed/drained. There is an approximately 90% chance that her cyst was a benign, functional cyst which would have resolved on its own (95% chance) with her next menstrual cycle. I would not be surprised if her surgery might actually have not been necessary.

Please feel free to call me at the above number, or to write to me at any time, should you have any further questions about this matter.

Thank-you.

Sincerely,

Christine M. Boulanger MD

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

June 10, 1992

Christine M. Boulanger, M.D.
Andover OB/GYN P.C.
140 Haverhill Street
Andover, Massachusetts 01810

Re: Complaint No. 92-156

Dear Dr. Boulanger:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Please be advised that Board Regulation 243 CMR 2.07 (12) requires that you respond within thirty days of your receipt of this letter. Your response should be sent to the Docket Administrator, Disciplinary Unit, at the above address. After your response is received, the case will be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Mary F. McGonagle

Mary F. McGonagle
Docket Administrator

Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 20, 1993

Re: Christine M. Boulanger, M.D.
Docket # 92-156

Dear Ms. :

I am writing in response to a telephone inquiry from your father. Unfortunately, I cannot give out any information regarding a complaint unless the inquiry is from the complainant or the physician.

As of today the complaint is waiting to be assigned to an investigator. The delay in assignment is due to our only investigator leaving our office. We are in the process of hiring new investigators and hopefully it will be assigned shortly. I have enclosed for you review a copy of the physician's response to your complaint. If you wish to make any comments please submit them in writing, and send it to my attention at the above address.

We will notify you in writing when the complaint has been resolved, or if additional information is needed by the investigator.

I apologize for the delay and thank you for your patience in this matter. If you have any more questions, please feel free to contact me at (617) 727-1788 extension 328 between 10:00 a.m. and 12:00 p.m.

Very truly yours,

Mary F. McGonagle
Docket Administrator

Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

June 10, 1992

Re: Christine M. Boulanger, M.D.
Docket #92-156

Dear Ms. :

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

Due to the large number of complaints requiring investigation by this office, and the reduction in staff levels due to the Board's budgetary constraints, your complaint cannot be assigned to an investigator at this time. As soon as an investigator becomes available, you will be contacted regarding the progress of your complaint.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to the Complaint Department at the address above. Be sure to include the physician's name and the complaint number on all correspondence.

Yours very truly,

Mary E. McGonagle

Mary F. McGonagle
Docket Administrator

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

June 10, 1992

Christine M. Boulanger, M.D.
Andover OB/GYN P.C.
140 Haverhill Street
Andover, Massachusetts 01810

Re: Complaint No. 92-156

Dear Dr. Boulanger:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Please be advised that Board Regulation 243 CMR 2.07 (12) requires that you respond within thirty days of your receipt of this letter. Your response should be sent to the Docket Administrator, Disciplinary Unit, at the above address. After your response is received, the case will be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Mary F. McGonagle

Mary F. McGonagle
Docket Administrator

Enclosure

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE, DISCIPLINARY UNIT, TEN WEST STREET, BOSTON, MA 02111

COMPLAINT FORM

PLEASE TYPE OR PRINT

YOUR LAST NAME _____ FIRST NAME _____

YOUR STREET ADDRESS _____

YOUR CITY, STATE, ZIP CODE _____

YOUR BUSINESS/DAYTIME PHONE _____ HOME PHONE _____

IS THIS A COMPLAINT AGAINST A M.D. PHYSICIAN (CIRCLE: M.D. OR D.O.) OR _____ ACUPUNCTURIST? (CHECK ONE)

Dr. Christine Boulanger

FULL NAME OF PHYSICIAN OR ACUPUNCTURIST (PLEASE CHECK SPELLING FOR ACCURACY)

140 Haverhill Street

ADDRESS

Andover, MA

CITY, STATE, ZIP CODE

BUSINESS PHONE OF PHYSICIAN OR ACUPUNCTURIST

(508) 475-2731

NAME AND LOCATION OF HEALTH CARE FACILITY (IF KNOWN)

Andover Doctors park Andover, MA

NATURE OF COMPLAINT - PLEASE INDICATE THOSE WHICH BEST DESCRIBE THE NATURE OF YOUR COMPLAINT.

- X MEDICAL MALPRACTICE
- ___ UNPROFESSIONAL CONDUCT
- ___ SEXUAL MISCONDUCT
- ___ PATIENT ABUSE
- ___ ALCOHOL MISUSE BY PHYSICIAN OR ACUPUNCTURIST
- ___ DRUG MISUSE BY PHYSICIAN OR ACUPUNCTURIST
- ___ MENTAL IMPAIRMENT OF PHYSICIAN OR ACUPUNCTURIST
- ___ DRUG DEALING
- X PATIENT NEGLECT/ABANDONMENT
- ___ CRIMINAL CONVICTION
- ___ PRACTICING WITHOUT A LICENSE
- ___ MEDICAID DISCRIMINATION
- ___ MEDICARE BALANCE BILLING
- ___ FAILURE TO SUPERVISE STAFF
- ___ FAILURE TO SUPERVISE PHYSICIAN ASSISTANT
- ___ FALSE ADVERTISING
- ___ MEDICAL RECORDS, FAILURE TO PROVIDE
- ___ MEDICAL RECORDS, COST
- ___ BILLING DISPUTE
- ___ OTHER Poor diagnostic proceedures Medical Incompetence

PLEASE TURN OVER AND COMPLETE OTHER SIDE

BRIEFLY DESCRIBE YOUR COMPLAINT HERE I have complained about severe abdominal pains, nausea. intense bloating for about 2-3 years while under the care of Dr. Boulanger. Staff and her recommendations were birth control prescriptions, motrin, ice tea drinks and Meclomen none of which elleviated my extreme discomfort. After no relief and collapsing and losing consciousness at work recently I retrived my medical records and sought out another physician. I was particularly upset when I called Dr Boulanger's office to explain what happened at work and the support I received was "Oh, that's too bad!". I was examined by Dr. who immediately suggested that it he suspected endometriosis or possibly an ovarian cyst. He schedlued me for day surgery and was operated on approximately 2½ weeks laterwhere he found and drained an ovarian cyst the size of a small orange. Since that time I have experienced no discomfort after suffering for over 2-3 years due to the medical incompetence of Dr. Boulanger and her staff.

I feel that she should have recommended further tests if she felt stymied by her inability to diagnosis the problem, instead of her staff stating "Don't worry all the pain will disappear when you have children." I feel I have suffered needlessly for the past 2-3 years.

Thank you for looking into this matter for me.

ATTACH THE DETAILS OF YOUR COMPLAINT TO THIS FORM. SEND COPIES - NOT ORIGINALS - OF RELATED DOCUMENTS.

YOUR SIGNATU _____ TODAY'S DATE: 12/20/91

RELEASE OF MEDICAL RECORDS AND INFORMATION

NAME OF PATIENT: _____

ADDRESS: _____

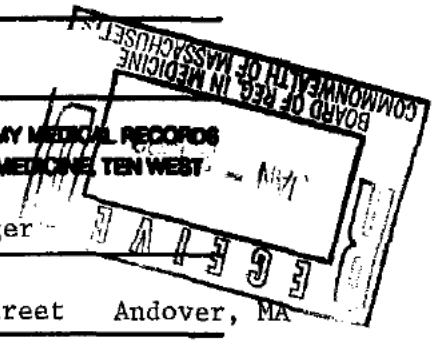
I HEREBY AUTHORIZE THE FOLLOWING PHYSICIAN OR INSTITUTION TO RELEASE MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE BOARD OF REGISTRATION IN MEDICINE, TEN WEST STREET, BOSTON, MASSACHUSETTS 02111.

NAME OF PHYSICIAN OR INSTITUTION: Dr. Christine Boulanger

ADDRESS: Andover Doctors Park 140 Haverhill Street Andover, MA

DATE OF SERVICES RENDERED: 1988-1991 (approx)

SIGNATURE OF PATIE
(OR LEGAL REPRESE _____ DATE: 12/20/91



MAIL THIS FORM TO: COMPLAINT COORDINATOR, DISCIPLINARY UNIT
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

FOR OFFICE USE ONLY:

DATE RECEIVED: ____/____/____ DOCKET NUMBER: _____-_____

Commonwealth of Massachusetts

Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

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

RECEIVED
JUL 20 1995
BOARD OF REGISTRATION IN MEDICINE

ALEXANDER F. FLEMING, J.D.
EXECUTIVE DIRECTOR
PENELOPE WELLS, J.D.
GENERAL COUNSEL

COMPLAINT FORM

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

☐ Mrs. ☑ Ms. ☐ Mr. Your First Name	Last Name	Patient Name (if different)
Street Address		Mailing Address (if different)
City	State	Zip Code
Business/Daytime Phone		Home Phone

Complaint against M.D. ✓, D.O. ____, Acupuncturist ____. **(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-3076, or 100 Cambridge St., Boston, MA 02202.)**

This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

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

Dr. Christine Boulanger

Address

22 Mill Street Suite 209

City | State | Zip Code

Arlington, MA 02174

Business Phone

617-646-1043

Name and Location of Health Care Facility (if known)

same as above

Nature of Complaint

- ☐ Substandard Medical Care
- ☐ Professional Misconduct
- ☐ Sexual Misconduct
- ☐ Rude or Discourteous Behavior
- ☐ Impaired by Alcohol or Drugs
- ☐ Impaired by Mental or Emotional Illness
- ☐ Failure to Provide Medical Records
- ☐ Overcharge for Medical Records
- ☐ Drug Dealing
- ☐ Criminal Conviction
- ☑ Patient Neglect/Abandonment
- ☐ Unlawful Discrimination
- ☐ Billing for Services Not Rendered
- ☐ Failure to Supervise Staff
- ☐ False Advertising
- ☐ Fraud
- ☐ Other Failure to request proper instructions on requisition form for lab test.

Please do not write below this line.

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

Release of Medical Records and Information

Patient Name: ____ Date of Birth: ?

Address:

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

Signature of Patient: Date: 7-24-96
(Or Legal Representat...)

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

Signature of Patient: Date: 7-24-96
(Or Legal Representative)

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

Laboratory
Mt. Auburn Hospital
330 Mt. Auburn St.
Cambridge, MA 02138
Ph: 499-5060

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

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

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

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

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

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

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

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

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

Dates of Treatment: _____ - 96

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

My initial visit on -96 was for a Pap Smere and to get examined for vaginal itching. I was diagnosed with a yeast infection and was prescribed by Dr. Boulanger, some antibiotics by the name of Macrodantin. The medicine required me to take doses of 4 a day. I felt very faint and dizzy the next day. I had a very bad headache and felt feeverish. I decided to suspend the medication. I had a bowel movement a day later and noticed a small pinkish round object bobbing in the water. It definetely did not appear to look like a stool expulsion. I called Dr. Boulanger and explained specifically what I had seen, and that I wanted this examined by the Laboratory. I had my boyfriend drop it off on Wednesday July 3rd. I was told to call next week to get a response back on what it was. I called the next week and was told the Dr. was either busy or not there. I left about 5 different messages on different days and explained to the Secretary my need to speak to Dr. Boulanger. She never expressed interest in returning any of my calls. I asked the Secretary

→ over

Attach copies of related documents to this form.
The information I ... of my knowledge.

Your signature: _ Date: 7-24-96

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111

if she could be paged and the Secretary said that it wasnt Possible. The last call I made, the Secretary mentioned that Dr. Boulanger was going to be taking her vacation the week of July 15th. I was feeling very abandoned because I was very worried and concerned about the object I had expulsed. I phoned the Laboratory and they reported they had been unable to do a P.O.P. because they didnt have enough to work with, and they had disposed of it. I asked the lady what the instructions on the requisition form read, and she stated it was for a POP examination. I specifically had explained to Dr. Boulanger that this was no stool specimen and she told me she clearly understood this. For all I knew, I could of had some sort of miscarriage by taking the prescribed doses of antibiotics Prescribed by Dr. Boulanger if Pregnancy had been. I finally received a call from Dr. Boulanger on July 23rd at work explaining the same thing over. She said that the Laboratory did not have enough of whatever it was to work with. I told her that the instructions on the requisition form were for a Parasites exam, and they were going to check out parasites but did not have enough ~~of~~ the specimen. She said that they were unable to identify

What it was because there was not enough of it. I really find it kind of hard to understand, how they could not identify this small round pinkish object. As a patient, I feel very neglected, and am having troubled thoughts on Perhaps what was the object I expulsed on 1996. I am not an expert on these matters of diagnosing objects expulsed within but, the description that most nearly fits it was a piece of fetus. I am going to be examined soon by another Gynecologist to ensure, if it was that, there are no remaining pieces inside. I would greatly appreciate it if you could review this and look into it further. Please let me know what can be done about this. I appreciate your help tremondously with this.

Thank you
Sincerely

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

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

ALEXANDER F. FLEMING, J.D.
EXECUTIVE DIRECTOR

PENELOPE WELLS, J.D.
GENERAL COUNSEL

RAFIK ATTIA, M.D.
CHAIRMAN

BRUCE A. SINGAL, J.D.
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NISHAN J. KECHEJIAN, M.D.
SECRETARY

ARNOLD S. RELMAN, M.D.
BOARD MEMBER

CARL M. SAPERS, J.D.
BOARD MEMBER

MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

September 19, 1996

Christine Marie Boulanger, MD

Re:
Docket Number: 96-295

Dear Dr. Boulanger:

The Complaint Committee of the Board has considered the above referenced complaint and has determined that no further action is warranted. The complaint has been dismissed.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please feel free to call me at (617) 727-1788, or write to me at the above address.

Very truly yours,

Charlene Morelli

Charlene Morelli
Administrative Assistant

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
(617) 727-3086
Fax: (617) 451-9568
An Agency within the Executive Office of Consumer Affairs and Business Regulation

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BOARD MEMBER
MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

September 19, 1996

Re: Christine Marie Boulanger, MD
Docket Number: 96-295

Dear Ms.

The Complaint Committee of the Board of Registration in Medicine has carefully considered the information you furnished it regarding your complaint against the physician referenced above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues you raised.

After a thorough review of this evidence, the Committee determined that your complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions or additional material which you wish the Board to consider, please write to Mary Lee, Consumer Protection Coordinator, at the above address.

Thank you again for your concern.

Very truly yours,

Charlene Morelli

Charlene Morelli
Administrative Assistant

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
(617) 727-3086
Fax: (617) 451-9568
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MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

September 19, 1996

RE: Christine Marie Boulanger, M.D.
Docket No: 96-295

Dear Ms.

Enclosed, is a copy of Dr. Boulanger's response to your complaint.

Very truly yours,

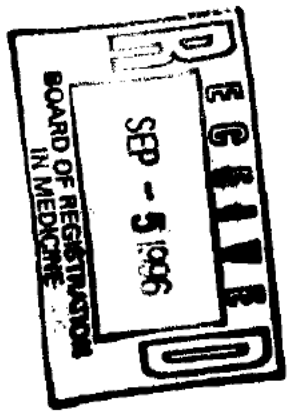
Charlene M. Morelli

Charlene M. Morelli
Consumer Protection Administrative Assistant

Enclosure

MOUNT AUBURN HOSPITAL

ARLINGTON WOMEN'S HEALTH
Christine Boulanger, M.D.



August 21, 1996
Commonwealth of Mass
Board of Registration in Medicine
10 West St.
Boston MA 02111

Attn: **Charlene Morelli**

Dear Ms. Morelli:

This in response to your letter of August 8th concerning patient , doc # 96-295. This patient is a 28 year old G2P2 woman who came to my office as a new patient on 1996. She had one visit with me. She reported dysuria for the past three weeks and a history of genital herpes in the past. She has had Norplant for the past 4 years and occasional irregular menstrual periods. On examination her thyroid, breast and abdomen exams were normal and her pelvic exam was normal. Pap smear was performed. Urine culture was greater than 100,000 organisms of skin flora. The patient did receive Macrodantin 50 mg. po qid for 7 days and I gave her a prescription for Zovirax 200 mg. 5 times a day for 5 days and also Monistat cream for presumptive vaginitis. Several days later, called back saying that she had thought she passed a firm mass in her stool during a bowel movement. She removed it from the toilet bowel and her boyfriend delivered it to my office. This firm mass appeared to be the pit of some sort of fruit. It was hard and there was no feces attached to it. Ms. was insistent that this be sent for laboratory evaluation despite my discussion with her that this firm, small mass looked very much like part of a peach pit or the pit of some fruit and that sending it for laboratory evaluation would probably not offer us any further enlightenment as to it's identity. I was however reasonably certain that it was the pit of a fruit. However, at the patient's insistence, I did send this specimen to the Mount Auburn Hospital laboratory and received a report back saying that a stool specimen evaluation was not performed as the specimen was inappropriate for the test, it being a rock, hard, small , firm mass very consistent with the pit of a fruit. I returned 's telephone call and informed her of these results and she denied any further episodes similar to the one she had had and also no evidence of hematochezia or symptoms attributable to her rectum. I also gave her instructions that should this episode happen again, she again return to my office and I would make further attempts to evaluate any stool sample that she could provide for me. She did not however, return to my office after our telephone call. In conclusion, appeared to have passed per rectum a small, firm mass which very much appeared like the pit of a peach or some other small fruit such as an apricot pit. This was sent to the laboratory for evaluation

A Harvard
Medical Center
Community
Teaching Hospital

22 Mill Street
Suite 204
Arlington, MA 02174
(617) 646-3420

MOUNT AUBURN HOSPITAL

ARLINGTON WOMEN'S HEALTH
Christine Boulanger, M.D.

and the laboratory evaluation was inconclusive due to the fact that they felt the specimen was inappropriate for a stool sample evaluation.

If you have any further questions concerning please do not hesitate to call me at 617-646-1540 or write to me at 10 Roger St. Apt 1219 in Cambridge MA. 02142.

Sincerely,

C Boulanger MD.

Christine Boulanger, M.D.
CB/cf

A Harvard
Medical Center
Community
Teaching Hospital

22 Mill Street
Suite 204
Arlington, MA 02174
(617) 646-3420

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
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BOARD MEMBER
CARL M. SAPERS, J.D.
BOARD MEMBER
MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

August 8, 1996

Christine Marie Boulanger, MD

Re:
Docket Number: 96-295

Dear Dr. Boulanger:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Your response should be sent to the Consumer Protection Coordinator, at the address above, within 30 days of your receipt of this letter. After your response is received, the case will be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Charlene Morelli

Charlene Morelli
Administrative Assistant

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

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

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BOARD MEMBER
CARL M. SAPERS, J.D.
BOARD MEMBER
MARY ANNA SULLIVAN, M.D.
BOARD MEMBER

August 8, 1996

Re: Christine Marie Boulanger, MD
Docket Number: 96-295

Dear Ms :

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

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to the Consumer Protection Department at the address above. Be sure to include the physician's name and the complaint number on all correspondence.

Very truly yours,

Charlene Morelli

Charlene Morelli
Administrative Assistant

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

Physician Registration Renewal Application

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

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

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

RECEIVED MAR 13 2001 BOARD OF REGISTRATION IN MEDICINE

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

1. Current Status: Active Registration No.: 58266 Renewal Date: 03/27/2001

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

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

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

3. A) Mailing/Business Address:
CHRISTINE MARIE BOULANGER

RECEIVED FEB 28 2001 BOARD OF REGISTRATION IN MEDICINE

B) Home Address:

Home Phone:

Business Phone: ~~(617)252-4312~~

Please make corrections (type or print)

Other Name(s):

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

Business Address:
City/Town: State:
Zip: Country:
Business Telephone: (781) 646-1043

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

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

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

c) SS#:

5. a) Name of Medical School:
University of Vermont College of Medicine
b) Year Graduated: 1982 c) Degree: M.D.

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

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

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

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

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

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

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

Facility Code: 71 / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s):

PRINT YOUR LAST NAME: BOULANGER LICENSE NUMBER: 58266

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

Name of Insurer: _____ Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 24 hrs/wk b) inpatient care 24 hrs/wk

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

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

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

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

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

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

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

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

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

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

Signature: Christine M. Boulanger MD Date: 2/26/01

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

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

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

PRINT NAME AND NUMBER: Last Name: BOULANGER Registration Number: 58266

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

IN THE PAST TWO (2) YEARS:	YES	NO

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Christine Boulanger MD Date: 2/26/01

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

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

Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.: 58266 Renewal Date: 03/27/2003

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

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

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

A) Mailing/Business Address:

3. CHRISTINE MARIE BOULANGER

B) Home Address:

Home Phone:

Business Phone: (781)646-1043

Please make corrections (print)

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

Mailing Address: 22 MILL STREET #208
City/Town: ARLINGTON State: MA
Zip: 02476 Country: USA

Business Address: 22 MILL STREET #208
City/Town: ARLINGTON State: MA
Zip: 02476 Country: USA
Business Telephone: (781) 6461043

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

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

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

5. a) Name of Medical School: University of Vermont College of Medicine
b) Year Graduated: 1982 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	80	Obstetrics and Gynecology

0

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

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

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

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

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

Facility Code: 71 / ✓ (AP) 99 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 42 / ✓ (AP) 1 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): ___

PRINT YOUR LAST NAME: BOULANGER LICENSE NUMBER: 58266

11. My medical malpractice insurance is covered by ☑ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): Controlled Risk Insurance Co. of Vermont Policy dates: From: 1/1/03 To: 12/31/03

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 0 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 50 %

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

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

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

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

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

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

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

Signature: Christine M. Boulanger MD Date: 2/5/03

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

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

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

PRINT NAME AND NUMBER: Last Name: BOULANGER License Number: 58266

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

IN THE PAST TWO (2) YEARS: **YES** **NO**

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Christine M. Boulanger MD Date: 2/5/03

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Massachusetts Physician Renewal Application

Physician Name: CHRISTINE MARIE BOULANGER **License No.:** 58266

PART A

1) Current Status: Active **Renewal Due Date:** 02/27/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
22 Mill Street
208
Arlington, MA 00247-6

☑ *Check here to change this address*

RECEIVED DEC 29 2004 Board of Registration in Medicine

Please make corrections (print)

Mailing Address: 22 Mill Street #102
City/Town: Arlington State: MA
Zip: 02476 Country: USA

2b) HOME ADDRESS

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

Home address cannot be a Post Office Box

Phone:
☑ *Check here to change this address*

2c) BUSINESS ADDRESS
22 Mill Street
208
Arlington, MA 00247-6

Phone: (781)646-1043
☑ *Check here to change this address*

Business Address: 22 Mill Street #102
City/Town: Arlington State: MA
Zip: 02476 Country: USA
Business Telephone: (781) 646-1043

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 781-643-4308

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: CHRISTINE MARIE BOULANGER **License No.: 58266**

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

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

Principal Work Setting: Hospital

Change to: _____ Hours per Week: _____

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

No Affiliations ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category		# Hours per Week
		Current	Change	
Martha's Vineyard Hospital	☐	Associate		1
Mount Auburn Hospital	☐	Active		40
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 30 hrs/wk Change to: _____ hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: *(required)* From 1/1/04 AND 1/1/05 To 12/31/04 12/31/05

☐ **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: CHRISTINE MARIE BOULANGER **License No.: 58266**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)*
If Yes, please complete Form PCA-O "Office Based Surgery"

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

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

	YES	NO
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

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: Christine M. Boulanger MD Date: 12/20/04

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: CHRISTINE MARIE BOULANGER **License No.: 58266**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Christine M. Boulanger MD Date: 12 / 20 / 04

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: CHRISTINE MARIE BOULANGER License No.: 58266

(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.)

8b) States where you were previously licensed (Abbr.) NH CA

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

Principal Work Setting: Hospital

Change to:

Hours per Week: 50

Amended C Boulanger 1/4/05

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

No Affiliations ☐

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category Current	Staff Category Change	# Hours per Week
Martha's Vineyard Hospital	☐	Associate		1
Mount Auburn Hospital	☐	Active		40
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 30 hrs/wk Change to: ____ hrs/wk

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

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

☑ Insurance Carrier: (complete below)

Current Insurance Carrier: CRICO

Policy dates: From (required) 1/1/04 AND 1/1/05 To 12/31/04 12/31/05 Change to: ____

☐ 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): ____

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

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

March 6, 2006

Christine Marie Boulanger, M.D.
22 Mill Street
#102
Arlington, Massachusetts 02476

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Re:
Docket Number: 06-161

Dear Dr. Boulanger:

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

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

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

Your response must be sent to me, at the address above, within thirty days of your receipt of this letter. After your response is received, the case will be reviewed and a determination will be made about how to proceed. You will be notified of this decision.

Thank you for your attention to this request.

Very truly yours,

Jennifer Brown JLS

Jennifer Brown
Consumer Protection Coordinator

JAB/jls
Enclosure

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

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

May 4, 2006

Christine Marie Boulanger, M.D.
22 Mill Street
#102
Arlington, Massachusetts 02476

Re:
Docket Number: 06-161

Dear Dr. Boulanger:

The Complaint Committee of the Board of Registration in Medicine met on May 3, 2006, and carefully considered the information both you and the complainant furnished in the above-referenced matter. They determined that no further action is warranted and the matter has been closed. Despite the decision to close the above complaint, the Board reserves the right to reopen the complaint should you commit any violations of Board statutes or regulations in the future.

If you have any questions regarding this matter, I can be reached at the number or address listed above.

Very truly yours,

Jennifer Brown

Jennifer Brown
Consumer Protection Coordinator

JAB/bmh

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

COMPLAINT FORM

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

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

Street Address Mailing Address (if different)

City State Zip Code

Business/Daytime Phone Home Phone

Complaint against M.D. _____, D.O. _____, Acupuncturist _____.

(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)

This complaint cannot be processed without the **full** name of the physician or acupuncturist. Please verify spelling.

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

CHRISTINE M. BOULANGER

Address

22 MILL ST.

City State Zip Code

ARLINGTON MA

Business Phone

Name and Location of Health Care Facility (if known)

Nature of Complaint

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

☐ OTHER _____

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

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS B DICINE.

Signature of Patient: _____ Date: 7/23/04
(Or Legal Representati

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

Signature of Patient: _____ Date: 7/23/04
(Or Legal Representative

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

DR. 2 LAHEY CLINIC
DR. 3

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

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

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

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

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

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

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

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

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

Dates of Treatment: _____ '04

07/27/06 15 90/12/10 128

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

See attached

Attach copies of related
The information in this

to the best of my knowledge.

Your signature: ____ Date: 7/29/04

Mail this form to: ...linator
Board of Registration in Medicine
560 Harrison Ave Suite G-4
Boston MA 02118

07/27/05 15 30/12/10 180

July 29, 2004

Dr. Christine Boulanger was my gynecologist. I've been seeing her for years, when her practice was in Andover, MA and when she moved to Arlington, MA.

When I was 40, she told me that I would now have to have a yearly rectal exam since that was a procedure performed annually on woman of my age. That was the only rectal exam she ever gave me.

In 2002 she performed a D & C because I complained frequently of mid-cycle bleeding.

On 2004, I went to her for my annual exam. Again, she did not perform a rectal exam. I was under the assumption that protocol must have changed and didn't ask her about it.

On 3, 2004, I had an MRI, prescribed by my PCP, because of recurring back and leg pain. The MRI results were negative for back or leg related problems but showed a very large mass on my uterus.

On 2004, I had an appointment with a GYN at Lahey Clinic. He palpated this large mass on my uterus not only vaginally but also during the rectal exam. Dr. ordered another MRI specifically for the pelvic area and determined that I needed a hysterectomy based on the size and rate that the mass was growing.

On th I had abdominal surgery. Based on the size of the tumor this procedure could not be done vaginally.

Dr. Boulanger's neglect could have resulted in several complications had I not gone to my PCP for leg/back pain. Dr. Boulanger is a danger to patients who go to her for annual exams. It is not acceptable that she did not feel (palpate) this tumor. It is also unacceptable for her not to have given me a rectal exam in which she may have discovered this. She told me everything was fine.

Dr. Boulanger is not doing her job proficiently and I believe lives are at stake. She should be, at the very least, reprimanded for such a careless exam on a patient.

Enclosed please find the pathology report done after my hysterectomy.

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

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

July 18, 2006

Christine Marie Boulanger, M.D.
22 Mill Street, # 102
Arlington, MA 02476

Re:
Docket Number: 04-451

Dear Dr. Boulanger:

The Complaint Committee of the Board of Registration in Medicine met on June 7, 2006 and carefully considered the information both you and the complainant furnished in the above-referenced matter.

The Committee has determined that no further action was warranted and the matter has been closed. Please note that although the Complaint Committee decided to close this complaint, the Board reserves the right to reopen this case should you commit any violations of Board statutes or regulations in the future.

If you have any questions regarding this matter, I can be reached at the number or address listed above.

Very truly your,

Loretta J. Villa, BSN, RN, LNC
Clinical Care Unit

LJV/gg

①

07/27/06 sl ep

16 August 2004

RECEIVED
2004 AUG 19 PM 12:39
BOARD OF REGISTRATION IN MEDICINE

Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, MA. 02118

Dear Ms. Kathleen M. Shea,

I am responding to your correspondence of 8/10/04, Docket # 04-451 (patient: ,). I have enclosed copies of her office record, in Arlington, MA. beginning , /99. I do not have access to her records from prior to that date from Andover OB/GYN, as I left that practice in 1994.

Firstly, In her letter of 7/29/04, Ms. , states that "enclosed please find the pathology report done s/p my hysterectomy". This report was not included in the documents I received from the Board: only a letter from Ms. , dated 7/29/04.

① Ms. , states that I told her she would have to have a yearly rectal exam beginning at age 40. This is not my policy: I usually perform annual rectal exams with stool guiac for home beginning at age 50. I do not recall telling her that routine rectal exams and guiac begin at age 40, since it is not my usual practice to do so.

② I performed a D+C on Ms. , 1/30/02, which was essentially benign. A pelvic ultrasound done 6/20/00 was reported as normal.

↘

[Patient: 7
Docket: 04-451]

(3) Ms 's pelvic exams of 99, 00, 01, 02, 04 were all normal, with normal PAP smear results (excepting inflammation). She had no particular complaints and no complaints of back pain at her annual exam 04.

In conclusion, I am summarizing Ms. 's exams at my office since 1999, and am including copy of her records from my office. I only received her letter * (copy also enclosed) from the Board, but I do not know the pathology on her hysterectomy because this was not enclosed in correspondence from the Board of August 10, 2004.

If I can be of any further help in this matter, please do not hesitate to call or write to me at the address below.

Sincerely,

Christine M. Boulanger MD
22 Mill St. #102
Arlington, MA 02476
o/c - 781-646-1043
home -

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

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

August 10, 2004

Christine Marie Boulanger, M.D.
22 Mill Street, # 208
Arlington, MA 00247-6

Re:
Docket Number: 04-451

Dear Dr. Boulanger:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate matters related to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide both a written response to the issues raised in the enclosed material, along with your complete file on this patient including but limited to any and all correspondence, photographs, lab reports and radiology reports. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Your response should be sent to me, at the address above, within 30 days of your receipt of this letter. After your response is received, the case may be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will, in any event, be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager

KMS\bmh
Enclosure

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite G-4
Boston, MA 02118

COMPLAINT FORM

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

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

Street Address Mailing Address (if different)

City State Zip Code

Business/Daytime Phone Home Phone

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

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.
Christine Boulanger, M.D.
Address
22 Mill St, Suite 102,
City State Zip Code
Arlington MA 02474
Business Phone (781) 646-1043
Name and Location of Health Care Facility (if known)
Mt. Auburn Midwives' Assoc. - 22 Mill St. (see above)

Nature of Complaint

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

☐ OTHER _____

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

Release of Medical Records and Information

Patient Name: _____ Date of Birth: ___/___/___

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BO

Signature of Patient: _____ Date: Feb. 26, 2006
(Or Legal Representativ

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

Signature of Patient: _____ Date: Feb. 26, 2006
(Or Legal Representativ

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

Dr. _____, M.D., and staff, 22 Mill St., Suite 101, Arlington, MA 02474. (Note: Not same address as Dr. Boulanger; they are in next suite over in same building, but are a different practice.) Primary care physicians. Phone: _____

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

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

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

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

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

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

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

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

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

Dates of Treatment: _____, 2005

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

I was seeking a permanent or at least long-term method of birth control. Dr. Boulanger suggested Depo-Provera. However, she did NOT tell me that Depo-Provera can aggravate/cause [redacted] depression and anxiety. I have suffered both conditions my entire adult life. This winter has been exceedingly difficult for me, as the hormonal changes wrought by the Depo-Provera injection have caused me to be depressed, anxious, irritable, weepy, and even thinking of suicide.

I wrote Dr. Boulanger a letter informing her that I would no longer be seeing her because of the above. I did not receive a response, although I was not expecting one.

[redacted]

Attacl
The ir

st of my knowledge.

Your ___ Date: Feb. 26, 2006

Mail this form to: Consumer Protection Coordinator
Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston MA 02118

Massachusetts Physician Renewal Application

Physician Name: Christine Marie Boulanger, M.D. **License No.: 58266**

PART A

1) Current Status: Active **Renewal Due Date:** 02/27/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

22 Mill Street
#102
Arlington, MA 02476

RECEIVED
JAN 23 2007
Board of registration in Medicine

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

22 Mill Street
#102
Arlington, MA 02476

Phone: (781)646-1043

☐ *Check here to change this address*

3) E-mail Address:

4) Fax Number: 781-643-4308

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	Delete?	List Additional Specialties:
Obstetrics and Gynecology	☐	
	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: Christine Marie Boulanger, M.D. **License No.: 58266**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		NH 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?
Martha's Vineyard Hospital			☐
Mount Auburn Hospital			☐
			☐
			☐
			☐

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

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

b) outpatient care 30 hrs/wk Change to: _____ hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/07 To 12/31/07

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Christine Marie Boulanger, M.D. **License No.: 58266**

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

YES **NO**

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

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

Massachusetts Physician Renewal Application

Physician Name: Christine Marie Boulanger, M.D. **License No.: 58266**

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: Christine M. Boulanger MD Date: 1/16/07

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

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

Dear Colleague:

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

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

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

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

Sincerely,

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Christine Marie Boulanger, M.D. **License No.: 58266**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs, and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	OBSTETRICS AND GYNECOLOGY
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	

NPI REQUIRED INFORMATION

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

Social Security Number:

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

Gender: ☐ Male ☑ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: Christine M. Boulanger MD Date: 1/16/07

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

FORM PCA-O (OFFICE BASED SURGERY)

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

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

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

☐ Level I Office ☐ Level II Office ☐ Level III Office

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

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

_____

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

_____

_____

_____

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

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

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

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

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

_____

_____

_____

Signed:_____ **Date:**__/___/____

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

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.

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

DEVAL L. PATRICK
GOVERNOR
TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR
NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

Christine Marie Boulanger M.D.
22 Mill Street
#102
Arlington, MA 02476

February 20, 2007

58266

Dear Dr. Boulanger:

You authorized the Board to apply for your National Provider Identifier (NPI) on your most recent renewal or initial license application. The Board has applied for the NPI number and the application has been rejected by the Center for Medicare and Medicaid Services (CMS) for the following reason(s):

Exact Duplicate - Exact SSN match with existing record

The most likely reason for this is that you or another third party has already applied for and received your NPI. If this is the case, please fill in the NPI number in the provided space on this letter, sign it, and return it to the Board in the enclosed green envelope. If this is not the case, please contact the Board at 617-654-9810.

National Provider Identifier: 1841260452

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

Signature: Christine M. Boulanger MD Date: 3/12/07

PLEASE MAIL THIS ORIGINAL COMPLETED FORM TO: Board of Registration in Medicine, 560 Harrison Avenue, G-4, Boston, Massachusetts 02118.