RECEIVED

DEC 30 2015

Board of Registration in Medicine

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Board of Registration in Medicine

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

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

FULL LICENSE APPLICATION

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

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

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

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

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

☒ M.D. ☐ D.O. ☐ PhD ☐ Other degree________ ☐ Male ☒ Female

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

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

Social Security Number: ___ Date of Birth: ___ Month Day Year

NPI (National Provider Identifier) Number: 1184983926

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

*Mailing Address ___ Number and Street Telephone: ___

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

Home Address: ___ Number and Street Telephone: ___

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

Business Address: Boston Medical Center YACC-4, 850 Harrison Ave Telephone: 617-414-2000
Number and Street

Boston	MA	02118
City	State/Province/Territory	Zip (or postal) Code

E-mail Address: ___ Fax number: 617-414-7212

Are you applying for licensure through FCVS? ☐ **Yes** ☒ **No**

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

Date Received: 12 / 30 / 15

Check #: 1006

Check Amount: $ 600

Initials: WL

Pre-medical School

		From	To
Name: University of Colorado	Degree: BA	Year: 2004	Year: 2007
Street: 40 UCB	City: Boulder		State: CO
Name:	Degree:	Year:	Year:
Street:	City:		State:

Medical School

Name: University of Colorado		Degree: MD
Street: 1635 Aurora Court	City: Aurora	State: CO
Name:		Degree:
Street:	City:	State:

Medical School Graduation Date: 05 / 2012
Month Year

Postgraduate Education:

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

		From	To
Facility: University of Connecticut	PGY Year: 1-4	7 / 12	present
Specialty: Obstetrics and Gynecology	City: Farmington		State: CT
Facility:	PGY Year:	/	/
Specialty:	City:		State:
Facility:	PGY Year:	/	/
Specialty:	City:		State:
Facility:	PGY Year:	/	/
Specialty:	City:		State:
Facility:	PGY Year:	/	/
Specialty:	City:		State:

Examination History

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

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

Examination	Number of attempts	Passed (P)	Failed (F)
USMLE Step I	1	☒ P	☐ F
USMLE Step II	1	☒ P	☐ F
USMLE Step III	1	☒ P	☐ F
NBME Part I		☐ P	☐ F
NBME Part II		☐ P	☐ F
NBME Part III		☐ P	☐ F
FLEX Component 1		☐ P	☐ F
FLEX Component 2		☐ P	☐ F
FLEX Pre-1985		☐ P	☐ F
NBOME Part I		☐ P	☐ F
NBOME Part II		☐ P	☐ F
NBOME Part III		☐ P	☐ F
COMLEX Level 1		☐ P	☐ F
COMLEX Level 2		☐ P	☐ F
COMLEX Level 3		☐ P	☐ F
COMVEX		☐ P	☐ F
LMCC – Single		☐ P	☐ F
LMCC – Part I		☐ P	☐ F
LMCC – Part II		☐ P	☐ F
State Board Exam	(State of examination and year)	☐ P	☐ F

Hospital Affiliations and Employment

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

		From	To
Facility: Hartford Hospital	Position: resident	7 / 2012	6 / 2016
Street: 80 Seymour St	City: Hartford	State: CT	
Facility: The Hospital of Central Connecticut	Position: resident	7 / 2012	6 / 2016
Street: 100 Grand St	City: ~~Hartford~~ New Britain	State: CT	
Facility: John Dempsey Hospital	Position: resident	7 / 2012	6 / 2016
Street: 263 Farmington Ave	City: Farmington	State: CT	

1. List other states (abbreviations) where you are currently or have ever had a full license: none ____ ____

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

3. List Board Certification(s): none

4. List your practice specialt(ies): Obstetrics and Gynecology

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

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

7. Reason for requesting a Massachusetts medical license: Starting fellowship in 7/2016

8. Name of Facility: Boston Medical Center
   Address: YACC-4, 850 Harrison Ave City: Boston

9. Anticipated starting date in Massachusetts: 07 / 01 / 2016

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

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

[signature] 12 / 15 / 15

Signature of Applicant — Month Day Year

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Sarah Lindsay
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature

12/22/15
Date of Signature

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

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

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

MEDICARE/TAX FORM

INSTRUCTIONS:

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

I, Sarah Lindsay,
(type or print name)

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

SIGNED: [signature] DATE: 12/6/2015

Social Security Number: -

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

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

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

SIGNED: [signature] DATE: 12/6/2015

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

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

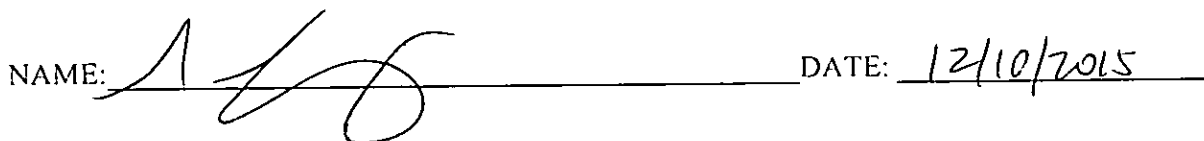
SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

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

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

SECTION 3. SIGNATURE

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



NAME: ______________________ DATE: 12/10/2015

Sarah F. Lindsay, MD

263 Farmington Ave
Department of Ob/Gyn
Farmington, CT 06030

Education

7/2012-present **University of Connecticut Obstetrics & Gynecology Residency Program**
Farmington, Connecticut

8/2008-5/2012 **University of Colorado Denver School of Medicine**
Aurora, Colorado
Doctor of Medicine, Global Health Track
Thesis: *Sigue Adelante: A peer-led curriculum for indigenous adolescent girls in Guatemala*
Advisor: Dr Eva Aagaard, MD

8/2004-12/2007 **University of Colorado Boulder, The College of Arts and Sciences**
Boulder, Colorado
Bachelor of Arts, Integrative Physiology; Minor, Political Science
Summa Cum Laude and High Honors
Thesis: *In Vitro Analysis of Human and Mouse Interleukin-6 Promoter Activity in C_2C_{12} Myoblasts*
Advisor: Dr David L. Allen, PhD

Certifications

1/23/2015 Council on Resident Education in Obstetrics and Gynecology In-Training Exam
Score: 227

1/24/2014 Council on Resident Education in Obstetrics and Gynecology In-Training Exam
Score: 235

1/26/2013 Council on Resident Education in Obstetrics and Gynecology In-Training Exam
Score: 207

3/2009-1/2013 United States Medical Licensing Exam Steps 1-3, passed

Professional Memberships

3/2015-present **Member**, Physicians for Reproductive Health

5/2011-present **Junior Fellow**, American Congress of Obstetricians and Gynecologists
3/2015-present UCONN Program Representative

8/2008-5/2012 **Member**, Colorado Medical Society Medical Student Section
8/2009-7/2010 Community Service Chair

8/2008-5/2012 **Member**, American Medical Society Medical Student Section

Peer-Reviewed Publications

Lindsay SL, Luciano DE, Luciano AL. Emerging therapy for endometriosis. Exert Opinion on Emerging Drugs. 2015 June; 20(3): 449-461

Allen DL, Cleary AS, Hanson AM, **Lindsay SF**, Reed, JM. CCAAT/enhancer binding protein-delta expression is increased in fast skeletal muscle by food deprivation and regulates myostatin transcription in vitro. American Journal of Physiology-Regulatory, Integrative, and Comparative Physiology. 2010 Dec; 299(6): R1592-1601

Allen DL, Cleary AS, **Lindsay SF**, Loh AS, Reed JM. Myostatin expression is increased by food deprivation in a muscle-specific manner and contributes to muscle atrophy during prolonged food deprivation in mice. Journal of Applied Physiology. 2010 Sept; 109(3): 692-701

Allen DL, Greyback BJ, Hanson AM, Cleary AS, **Lindsay SF**. Skeletal muscle expression of bone morphogenetic protein-1 and tolloid-like-1 extracellular proteases in different fiber types and in response to unloading, food deprivation and differentiation. Journal of Physiological Sciences. 2010 Sept; 60(5): 343-352

Allen DL, Uyenishi JJ, Cleary AS, Mehan RS, **Lindsay SF**, Reed JM. Calcineurin activates interleukin-6 transcription in mouse skeletal muscle in vivo and in C_2C_{12} myotubes in vitro. American Journal of Physiology-Regulatory, Integrative, and Comparative Physiology. 2010 Jan; 298(1): R198-R210

Allen DL, Cleary AS, **Lindsay SF**, Speaker KJ, Uyenishi JJ, Reed JM, Madden MC, Mehan RS. Myostatin, activin Receptor IIb, and follistatin-like-3 gene expression is altered in adipose tissue and skeletal muscle of obese mice. American Journal of Physiology-Endocrinology and Metabolism. 2008 May; 294(5): E918-E927

Other Publications

Lindsay SF, Oberle AM, Nguyen V, Weimer CM, Nash A. 2011. Aurora Lights Problem Based Learning Program, Curriculum and Instructor's Guide. University of Colorado Denver, Aurora Lights Program

Weimer C, **Lindsay SF**, Lee R, Aagaard E. 2011. Sigue Adelante: A peer-led curriculum for indigenous adolescent girls in Guatemala: Curriculum and Instructor's Guide. University of Colorado Denver, Global Health Track

Invited Presentations

11/15/2015 **Lindsay SF**, Nelson A, Morosky C
Poster Presentation: Provider type is not associated with intrauterine device expulsion
North American Forum on Family Planning
Chicago, Illinois

9/10/2015 **Lindsay SF,** Nelson A, Morosky C
Poster Presentation: Provider type is not associated with intrauterine device expulsion
Connecticut Resident Research Day
New Haven, Connecticut

3/6/2015 **Lindsay SF,** Melman L, Morosky C, Isaacs C
Film Festival Presentation: Neonatal Circumcision Model
Association of Professors of Gynecology and Obstetrics/Council on Resident Education in Obstetrics and Gynecology Annual Meeting, San Antonio, Texas

12/15/2009 Weimer C, **Lindsay SF**, Lee R, Aagaard E
Poster Presentation: Determining the Effectiveness of the *Sigue Adelante (Moving Forward)* Capacity Building Course
Student Research Forum, University of Colorado Denver, Aurora, Colorado

11/6/2009 Weimer C, **Lindsay SF**, Lee R, Aagaard E
Poster Presentation: Determining the Effectiveness of the *Sigue Adelante (Moving Forward)* Capacity Building Course
American Medical Association Interim Meeting, Houston, Texas

10/2/2009 Weimer C, **Lindsay SF**, Lee R, Aagaard E
Oral Presentation: Determining the Effectiveness of the *Sigue Adelante (Moving Forward)* Capacity Building Course
Global Health Symposium, University of Colorado Denver, Aurora, Colorado

11/2007 **Lindsay SF**, Allen DL
Poster Presentation: In Vitro Analysis of Human and Mouse Interleukin-6 Promoter Activity in C_2C_{12} Myoblasts
Howard Hughes Medical Institute Undergraduate Research Program, University of Colorado, Boulder, Colorado

Other Presentations

4/9/2015 **Lindsay SF**
Complications of Second Trimester Abortion
Department of Obstetrics and Gynecology Grand Rounds
Hartford Hospital, Hartford, Connecticut

3/26/2014 **Lindsay SF**
Turner Syndrome
Department of Obstetrics and Gynecology Grand Rounds
The Hospital of Central Connecticut, New Britain, Connecticut

11/14/2013 **Lindsay SF**
Management of Nausea and Vomiting of Pregnancy
Department of Obstetrics and Gynecology Grand Rounds
Hartford Hospital, Hartford, Connecticut

2/8/2010 Weimer C, **Lindsay SF**, Lee R, Aagaard E
Determining the Effectiveness of the *Sigue Adelante (Moving Forward)* Capacity Building Course
Department of Obstetrics and Gynecology Grand Rounds
University of Colorado Hospital, Aurora, Colorado

Research

9/2013-present **Co-Investigator**
Provider type and level of training as risk factors for intrauterine device expulsion
University of Connecticut Department of Obstetrics and Gynecology
Advisors: Drs. Christopher Morosky, MD, Amy Nelson, MD

1/2009-5/2012 **Co-Investigator**
Determining the effectiveness of the *Sigue Adelante (Moving Forward)* capacity building course
University of Colorado Global Health Track; Santa Rita, Guatemala
Advisors: Drs. Eva Aagaard, MD, Rita Lee, MD

2/2005-6/2008 **Undergraduate and Professional Research Assistant**
Muscle Molecular Physiology Laboratory, Department of Integrative Physiology
University of Colorado Boulder
Advisor: Dr. David L. Allen, PhD

Awards and Honors

6/29/2015 Gold Humanism Honor Society Award

6/19/2014 The Gretchen Allen Award for Dedication to Outstanding Care in the Women's Clinic at Hartford Hospital

6/19/2014 University of Connecticut Obstetrics and Gynecology Residency Program Grand Rounds Award, best resident Grand Rounds presentation

6/19/2014 University of Connecticut Obstetrics and Gynecology Residency Program "Smarty Pants" Award, highest CREOG In-Training Exam score for PGY2 class

10/2009 Global Health Track Presentation Award, best presentation at Global Health Symposium

5/2009 Rotary International Student Scholarship

12/4/2006 Induction, Phi Beta Kappa Honor's Society

Leadership and Academic Achievements

3/2015-present **Advocacy Chief Resident**
University of Connecticut Obstetrics and Gynecology Residency Program
Farmington, Connecticut

4/2013-present **Member**, Program Evaluation Committee
University of Connecticut Obstetrics and Gynecology Residency Program
Farmington, Connecticut

10-11/2014 **Course Certificate**
Abortion: Quality Care and Public Health Implications, Web-Based Curriculum

University of California San Francisco, San Francisco, California

4/2010-5/2011 **Course Certificate**
Fundamentals of Quality Improvement, Web-Based Curriculum
Institute for Healthcare Improvement Open School for Health Professions

3/2010 **Superior Work Acknowledgement**
Ethics in Healthcare Professions Course
University of Colorado Denver School of Medicine, Aurora, Colorado

Service Activities

7/2014-present **Resident Co-Advisor**
Obstetrics and Gynecology Medical Student Scholars
University of Connecticut School of Medicine, Farmington, Connecticut

10/2009-5/2012 **Co-Founder and Board Member**
Aurora Lights Problem Based Learning Program
University of Colorado Denver School of Medicine, Aurora, Colorado

1-10/2009 **Board Member**
Peer-Led Review Sessions
University of Colorado Denver School of Medicine, Aurora, Colorado

3/11-3/19/2006 **Participant**, Medical Mission to Costa Rica
Foundation for International Medical Relief of Children, San Jose, Costa Rica

Technical Skills

Spanish proficiency

Professional Interests

General obstetrics and gynecology, family planning, health care policy, academic medicine

Board of Registration in Medicine
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www.mass.gov/masssmedboard

MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of your current and all past liability carrier(s). You must provide your malpractice history reports if you ever had a full license in any state. You do not need to supply your malpractice history reports while participating in an ACGME postgraduate training program unless you had a full license or you were named in a malpractice case. This form must be returned to the Board with your license application.

Please provide the following information on the malpractice history report:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: **Please report any open or closed cases that have gone to trial, whether or not monies were paid, and provide a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant. If the applicant does not have any claims history, please indicate that on your letterhead. If your company's name has changed, please provide any former company names. The information should be sent to the applicant.**

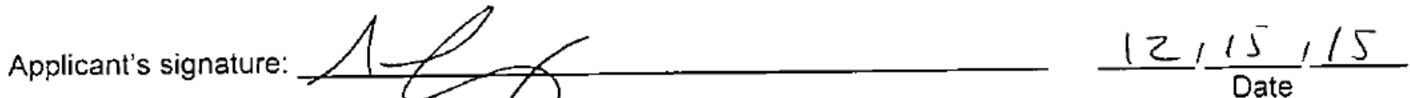
Liability Carrier: *none - see attached (N/A)* From: ___/___ To: ___/___
City: ______ State: ______ Policy #: ______

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy #: ______

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy #: ______

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy #: ______

Liability Carrier: ______ From: ___/___ To: ___/___
City: ______ State: ______ Policy #: ______

Applicant's signature:  *12/15/15*
Date

Print Name: *Sarah Lindsay*

Address: ______

City: ______ State: ______ Zip code: ______

Additional forms available at the Board's website at www.mass.gov/massmedboard.

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

MEDICAL EDUCATION VERIFICATION

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

Waiver for Release of Information

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

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

Print or Type Name: Lindsay (Last Name) Sarah (First Name) F (Middle Initial) U.S. Social Security No:

Other Name(s): ______________________
(Please type or print.)

Name of Medical School: University of Colorado

Address: 1635 Aurora Court City: Aurora State or Province: Colorado

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above-named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Colorado Boulder

Undergraduate School Address: Boulder, CO

Enrollment and Participation: Our records indicate that Lindsay (Last Name) Sarah (First Name) F (Middle Initial)
(print the applicant's name):

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

ATTENDANCE DATES:

FROM	TO	FROM	TO
08/11/2008	06/05/2009	05/09/2011	05/25/2012
08/17/2009	03/12/2010	__/__/__	__/__/__
04/19/2010	05/06/2011	__/__/__	__/__/__

Graduation Date (month/year): 05 / 2012

The applicant attended 164 **total weeks** ***or*** 41 **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

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

YES **NO**

1. Was the medical school training more than four (4) years for U.S. graduates or six (6) years for international medical graduates?
2. Did the applicant take any leaves of absence (i.e., for research, public service, participation in an M.D./Ph.D. program, or for any "personal reasons")?
3. Was the applicant ever placed on probation?
4. Was the applicant ever disciplined or under investigation?
5. Were any negative reports ever filed by instructors regarding the applicant?

Seal Verified
DATE: 12/31/15
INITIALS: WG

Please provide a detailed explanation if you answered "YES" to any of the above questions.

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: [signature]
Print Name: Terri Blevins
Title: Assistant Dean for Student Affairs
Date: 12/16/2015 Telephone: (303) 724 6407
E-mail address: terri.blevins@ucdenver.edu

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

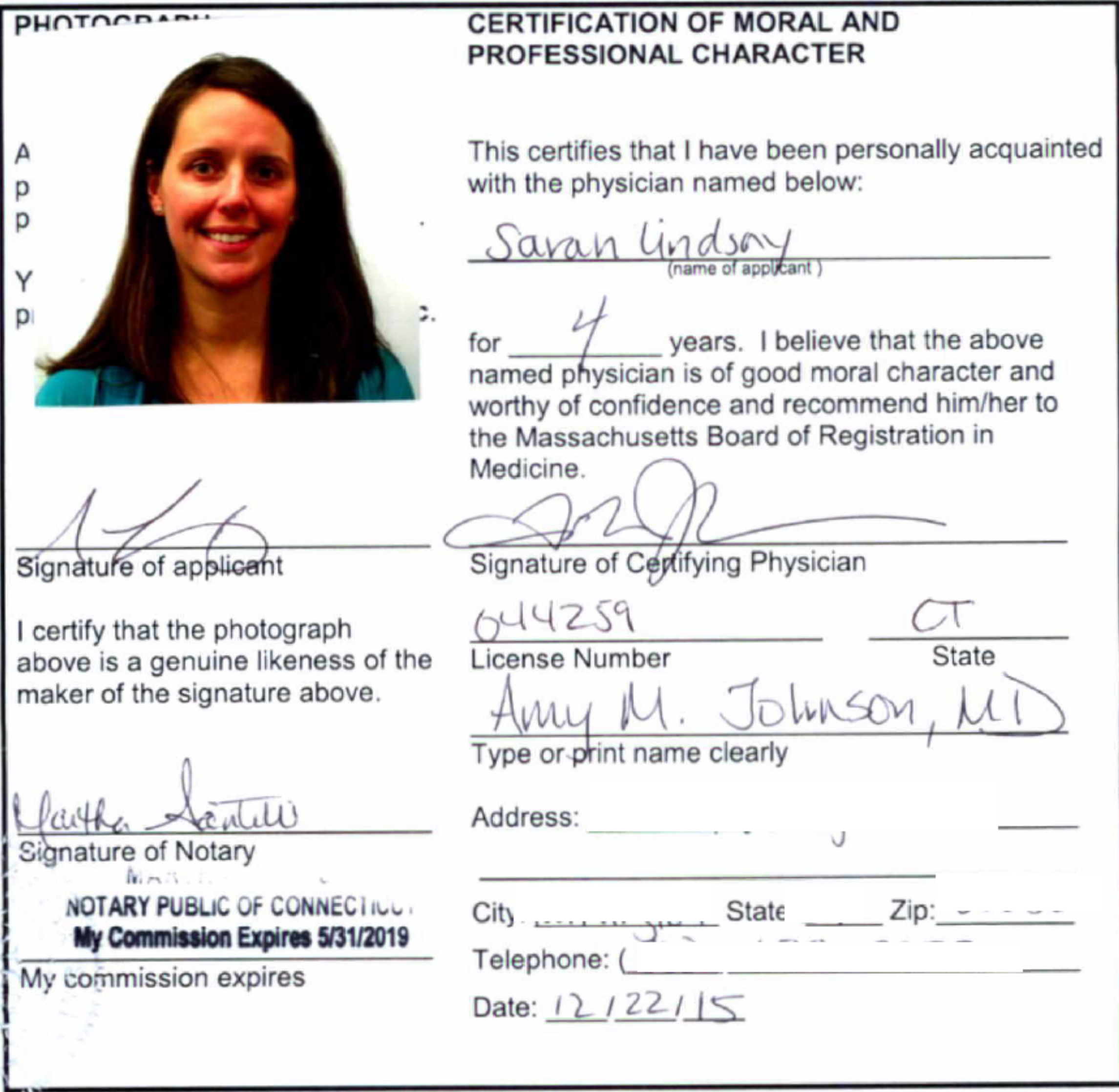
Sealed Envelope
Initials: WG

Seal Verified
DATE: 12/31/15
INITIALS: WG

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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



PHOTOGRAPH

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Sarah Lindsay
(name of applicant)

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

Signature of applicant

Signature of Certifying Physician

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

644259 — License Number
CT — State

Amy M. Johnson, MD
Type or print name clearly

Signature of Notary

NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 5/31/2019

My commission expires

Address:

City State Zip:

Telephone: (

Date: 12/22/15

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

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 12/6/2015

Print or Type Name: Sarah Lindsay

Name of Institution: University of Connecticut

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: University of Connecticut School of Medicine Obstetrics & Gynecology Residency

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

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

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
internship	1	Ob-gyn	7/1/12	6/30/13	Yes	ACGME
residency	2-4	ob-gyn	7/1/13	6/16/16		ACGME
residency	2	ob-gyn	7/1/13 -	6/30/14	Yes	ACGME 3/23/16
residency	3	ob-gyn	7/1/14 -	6/30/15	Yes	ACGME 3/23/16
residency	4	Ob-gyn	7/1/15 -	6/16/16	NO	ACGME 3/23/16

(Continued on page 2)

APPLICANT'S NAME: Sarah Lindsay

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

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

Seal Verified
DATE: 12/31/15
INITIALS: WG

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

COMMENTS: ____________

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

Program Director's Signature: [signature]

Print Name: Amy M Johnson

Academic Title: Residency Director

Telephone: (860) 679-2853 Today's Date: 12/22/15

E-mail address: amy.johnson@uhchealth.org

AFFIX INSTITUTIONAL SEAL HERE

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

MARTHA SANTILLI
NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 5/31/2019
Martha Santilli 12/22/15

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

PRINT NAME: Sarah Lindsay DATE: 12 / 6 / 2015

FULL LICENSE APPLICATION SUPPLEMENT

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

QUESTIONS **YES** **NO**

1. While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)

2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?

2-B. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?

3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?

4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?

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

6. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)

7. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?

8-A. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?

8-B. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)

PRINT NAME: Sarah Lindsay DATE: 12 / 6 / 15

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Sarah Lindsay DATE: 12 / 6 / 2015

CONFIDENTIAL INFORMATION

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

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

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

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

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

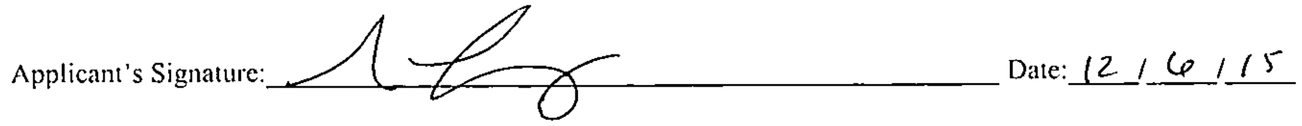
If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Sarah Lindsay DATE: 12 / 6 / 15

CERTIFICATIONS

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

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



Applicant's Signature: ______________ Date: 12 / 6 / 15

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

RECEIVED DEC 20 2017 Board of Registration in Medicine

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Connecticut Department of Public Health - Physician Licensure

ADDRESS: 410 Capitol Ave, MS #12APP, PO Box 340308

CITY: Hartford STATE: CT ZIP: 06134-0308

PHYSICIAN'S NAME: Sarah Lindsay

BUSINESS ADDRESS: 850 Harrison Ave YACC5

CITY: Boston STATE: MA ZIP: 02118

MASSACHUSETTS LICENSE NUMBER: 265698

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: 12/18/2017

Date Received: 12/20/17
Check #: 1024
Check Amount: $ 10
Initials: SM

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sarah F Lindsay, M.D. **License No.:** 265698

Current Status: Active **License Expiration Date:** 2/22/2019

1) **Activity Status:** Inactive

2) **Address & Contact Information**

Mailing Address:
WAHS
474 Hudston St
Hartford
Connecticut - 06106
United States of America

Home Address:

Business Address:
474 Hudson St
Hartford
Connecticut - 06106
United States of America
(860) 972-2780

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

WorkSite	Location
	None Reported

---

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

This question does not apply to inactive physicians.

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

This question does not apply to inactive physicians.

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

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

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

This question does not apply to inactive physicians.

23) Do you have a medical or physical condition that currently impairs your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sarah F Lindsay, M.D. **License No.:** 265698

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sarah F Lindsay, M.D. **License No.:** 265698

Current Status: Active **License Expiration Date:** 2/22/2017

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
BMC, YACC- 5
850 Harrison Ave
Boston
Massachusetts - 02118
United States of America

Home Address:

Business Address:
BMC, YACC- 5
850 Harrison Ave
Boston
Massachusetts - 02118
United States of America
(617) 414-2000

3) **Email Address:**

4) **Fax Number:** (617) 414-7212

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

WorkSite	Location
Boston Medical Center	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Ctr Ins.	07/01/2016	06/30/2017	Claims made with tail coverage

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

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

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

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Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

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

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sarah F Lindsay, M.D. **License No.:** 265698

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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