90-Day Form

Dear Doctor,

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

Thank you.

Please select one of the boxes below:

☑ Do not hold my Full License Application; send it to the Board as soon as it is completed.

☐ Hold my Full License Application until it is within the 90-day time period.

My birthdate is _____
Month Day Year

Signature: Kanthi Dhadwai Today's Date: 12 / 28 / 2017
Month Day Year

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

27A-147

RECEIVED
JAN 19 2018
Board of Registration in Medicine

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)

DHADUVAI, KANTHI
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: 1245613942

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

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: 195 CANAL STREET Telephone: 781-338-0500
Number and Street

MALDEN MA 02148
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: _____

Are you applying for licensure through FCVS? ☐ Yes ☑ No

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

Date Received: 1/19/18

Check #: 226

Check Amount: $ 60.00

Initials: CM

Pre-medical School | From | To

Name: University of Florida Degree: BS Year: 2007 Year: 2010
Street: 201 Criser Hall, PO Box 114000 City: Gainesville State: FL

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

Medical School

Name: NEW YORK MEDICAL COLLEGE Degree: M.D
Street: 40 SUNSHINE COTTAGE ROAD City: VALHALLA State: NY

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

Medical School Graduation Date: 05 / 2015
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: Tufts University Family Medicine Residency at CHA	PGY Year: 1	07/2015	06/2016
Specialty: Family Medicine	City: Malden		State: MA
Facility: Tufts Univ. Family Medicine Residency at CHA	PGY Year: 2	07/2016	06/2017
Specialty: Family Medicine	City: Malden		State: MA
Facility: Tufts Univ. Family Med Residency at CHA	PGY Year: 3	07/2017	present
Specialty: Family Medicine	City: Malden		State: MA
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) or Failed (F)
USMLE Step I	_____	☑ P ☐ F
USMLE Step II	_____	☑ P ☐ F
USMLE Step III	_____	☑ 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: Cambridge Health Alliance	Position: Resident	07/2015	present
Street: _____ City: Malden		State: MA	
Facility: Tufts University Medical School	Position: Clinical Associate	07/2015	present
Street: _____ City: Boston		State: MA	
Facility: Beth Israel Deaconess Med Cent	Position: Resident	07/2015	present
Street: _____ City: Boston		State: MA	

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): Family Medicine

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: practice

8. Name of Facility: Tufts Univ. Family Medicine at CHA
   Address: 195 Canal Street City: Malden

9. Anticipated starting date in Massachusetts: 08/01/2018

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.

Kavitha Dhadwai — Signature of Applicant

12 / 28 / 2017 — 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, KANTHI DHADUVAI
(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.

Kanthi Dhaduvai
Applicant's Signature

12/28/2017
Date of Signature

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

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

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

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

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

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

SECTION 3. SIGNATURE

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

NAME: Kavithi Dhaduvai DATE: 12/28/17

Kanthi Dhaduvai, M.D.

Professional interest: Family medicine with concentration in full-spectrum reproductive health

EDUCATION

Residency 07/2015 – present	Tufts University Family Medicine Residency at Cambridge Health Alliance Malden, MA
Medical School 08/2011 – 05/2015	New York Medical College, Valhalla, NY Doctor of Medicine
Undergraduate 08/2007 – 12/2010	University of Florida, Gainesville, FL Bachelor of Science, Microbiology & Cell Science

ACADEMIC APPOINTMENTS

07/2015 – present	Clinical Associate, Family Medicine, Tufts University

ACADEMIC and ADVOCACY EXPERIENCE

07/2016 – present	**Area of Concentration in Reproductive Health** Dedicate residency elective sessions to complete high volume abortion training, including hands-on manual vacuum aspiration and electric vacuum aspiration up to 14 weeks gestation.
07/2017 – present	**Co-leader, Wellness Weight Loss Group** Lead a weekly group visit for overweight and obese patients to gain basic health education, learn mindfulness-based skills, and develop healthier habits at Malden Family Medicine Center. Malden, MA
11/2016 – present	**Resident leader, Patient Advisory Council** Contribute to clinical improvement projects and facilitate monthly meetings of PAC, a collaborative working group consisting of patients and clinic staff at Malden Family Medicine Center. Malden, MA
08/2015 – present	**The Sharewood Project**, Tufts University School of Medicine Act as resident preceptor for students providing free healthcare to residents of the greater Boston area. Malden, MA

March 2017 **Co-leader, medical abortion workshop**
Led a skills workshop on medical abortion basics for primary care providers trying to start abortion services at their sites, through the Reproductive Health Access Project (RHAP) Eastern Massachusetts Network Cluster. Malden, MA

December 2016 **Co-leader, women's health skills session**
Led a didactic about contraception options for medical students. Center for Primary Care, Harvard Medical School. Cambridge, MA

01/2013 – 01/2015 **Volunteer, La Casita de Salud: NYMC student-run free clinic**
Worked with an attending to evaluate and treat uninsured patients.
Harlem, NY

08/2012 – 06/2013 **Treasurer, NYMC Infectious Disease Club**
Valhalla, NY

- Managed club expenses and co-led educational events such as "Wear Red for World AIDS Day" and "Infectious Disease Week."
- Developed presentation on "Myths & Facts about Immunizations" during 2012 NYMC Annual Health Fair.
- Collaborated with NYMC's LGBTQ club to fundraise and participate as a team in the 2013 New York City AIDS Walk.

LICENSES / CERTIFICATIONS

Ultrasound training course (Planned Parenthood Rocky Mountains, completed 12/2017)
Massachusetts Limited Medical License (07/2015 - present)
Advanced Life Support in Obstetrics (completed 01/2016)
Neonatal Resuscitation Program (completed 07/2015)
Basic Life Support (completed 05/2017)
Advanced Cardiac Life Support (completed 05/2017)
Suboxone Waiver Training (American Academy of Addiction Psychiatry, completed 09/2016)

PROFESSIONAL MEMBERSHIPS

American Academy of Family Physicians (AAFP)
Massachusetts Academy of Family Physicians (MAFP)
AAFP Reproductive Health Care Member Interest Group

PRESENTATIONS

"Decreased Sexual Interest & Arousal in Females: Beyond Checking the TSH." Cambridge Health Alliance Family Medicine Grand Rounds. November, 2017.

Dhaduvai, K, Charles, A. Sexual and Reproductive Health Education for Teen Group Home Residents in Malden, MA. Poster. *Cambridge Health Alliance Academic Poster Session.* April, 2017.

PUBLICATIONS

Strle F, Wormser GP, Mead P, **Dhaduvai K,** Longo MV, Adenikinju O, Soman S, Tefera Y, Maraspin V, Lotrič-Furlan S, Ogrinc K, Cimperman J, Ružić-Sabljić E, Stupica D. Gender disparity between cutaneous and non-cutaneous manifestations of lyme borreliosis.□*PLoS One,* 2013 May 30;8(5):e64110.

Joo JH, Taxter TJ, Munguba GC, Kim YH, **Dhaduvai K,** Dunn NW, Degan WJ, Oh SP, Sugrue SP. Pinin modulates expression of an intestinal homeobox gene, Cdx2, and plays an essential role for small intestinal morphogenesis. *Dev Biol,* 2010 Sep 15;345(2):191-203.

INTERESTS / EXTRACURRICULARS

A cappella, fiction novels, yoga

PRINT NAME: KANTHI DHADUVAI DATE: 12/28/2017

FULL LICENSE APPLICATION SUPPLEMENT

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

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: KANTHI DHADUVAI DATE: 12/28/2017

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

PRINT NAME: KANTHI DHADUVAI DATE: 12/28/2017

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: KANTHI DHADUVAI DATE: 12/28/2017

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: Kanthi Dhaduvai Date: 12/28/2017

Sealed Envelope

Initials: MJ

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:

Kanthi Dhaduvai
(name of applicant)

for 3 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.

Kanthi Dhaduvai
Signature of applicant

Signature of Certifying Physician

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

232606 — License Number
MA — State

GREGORY LARSON SAWIN
Type or print name clearly

Address: Tufts University
Family Medicine Residency
at Cambridge Health Alliance
195 Canal Street
Malden, MA 02148-6701

City: ____ State: ____ Zip: ____

Telephone: (781) 338-0550

Date: 1/12/2018

Signature of Notary

2/17/23
My commission expires

JANELL C. CORBETT
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 17, 2023

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.

Seal Verified
DATE: 1 22 18
INITIALS: MJ

Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that Kanth Dhaduvai
(Student's Name)

has completed the requirements for the [X] M.D. degree [ ] D.O. degree

from New York Medical College
(Name of Medical School)

and will receive the degree on 5 / 21 / 15.

Signature of Certifying Official:
(Original Signature is required – Stamps not accepted)

Printed Name: Jennifer Simmons

Title: University Registrar

Date: 5/26/15

The completed Form B may be faxed to the Limited License Coordinator at (781) 876-8383 or mailed to the Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880. Telephone: 781-876-8210.

Thank you.

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

Applicant's Signature: Kanthi Dhaduvai Date of Birth: ___

Print or Type Name: DHADUVAI (Last Name) , KANTHI (First Name) (Middle Initial) U.S. Social Security No

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

Name of Medical School: New York Medical College

Address: 40 Sunshine Cottage Road City: Valhalla State or Province: New York

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 Florida

Undergraduate School Address: N/A

Enrollment and Participation: Our records indicate that Dhaduvai (Last name) Kanthi (First name) (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
	8 / 1 / 11	6 / 30 / 12	7 / 7 / 14	5 / 21 / 15
	8 / 13 / 12	6 / 23 / 13	/ /	/ /
	6 / 24 / 13	6 / 30 / 14	/ /	/ /

The applicant attended 183 total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year.

check one ☐ was awarded a degree in _____ on (month/day/year) ____/____/____

☒ will be awarded on 5 / 21 / 15 (Form B must also be completed and returned directly to the Board.)

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

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: _____

Print Name: Jennifer Simmons

Title: University Registrar

Date: 4 / 20 / 15 Telephone: (914) 594-4495

E-mail address: Registrar@nymc.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: MJ

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: Kanthi Dhaduvai Date: 12/28/2017

Print or Type Name: KANTHI DHADUVAI

Name and Address of Institution: Tufts University Family Medicine Residency at Cambridge Health Alliance
195 Canal Street
Malden, MA 02148

TO BE COMPLETED BY PROGRAM DIRECTOR

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

Name of Institution: Tufts University Family Medicine Residency Cambridge Health Alliance

Name of Institution, if different when applicant attended: _____

Verification for: Kanthi Dhaduvai, MD
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
Internship	PGY1	Family Medicine	7/1/15	6/30/16	Yes	ACGME
Residency	PGY2	Family Medicine	7/1/16	6/30/17	Yes	ACGME
Residency	PGY3	Family Medicine	7/1/17	6/30/18	In Progress	ACGME
			/ /	/ /		
			/ /	/ /		

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

APPLICANT'S NAME: KANTHI DHADWAI

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

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

COMMENTS: Excellent clinician!

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: [signature] MD, MPH

Print Name: Gregory Sawin, MD, MPH

Academic Title: Program Director

Telephone: (781) 338-0550 Today's Date: 1/2/18

E-mail address: gsawin@challiance.org

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

Seal Verified
DATE: 1 22 18
INITIALS: MJ

Sealed Envelope

Initials: MS

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

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:

- *This form must be completed by a supervising physician who can evaluate your clinical performance.*
- *At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.*
- *Evaluation forms must be current within 120 days prior to Board review.*
- *The Evaluator must have no financial interest in your licensure in the State of Massachusetts.*

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

Signature of applicant: Kanthi Dhaduvai Date: 12 / 28 / 2017

Please PRINT your name: KANTHI DHADUVAI

Name of Evaluating Hospital/Workplace: CHA Malden Family Medicine State: MA

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. **Date(s) of applicant's affiliation at facility (month/year)?** From: 7 / 15 To: 6 / 2018

2. **In what capacity did you supervise the applicant?** ☐ Department Chair ☐ Chief of Service ☐ Medical Director ☒ Training Director ☐ Supervising Physician ☐ Chief Medical Office

3. **Applicant's Status:** ☐ Intern ☒ Resident ☐ Fellow ☐ Staff Member ☐ Other _____

4. **Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts?** ☐ YES ☒ NO

5. **Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).**

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

(Continued on page 2)

6. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? ☐YES ☒NO (if "yes" please explain below)

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

8. Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.

Excellent family physician! Strong clinical skills and great communicator.

9. The above comments are based on the following:

☒ Personal observation ☒ General impression ☒ A composite of evaluations by other physicians

☐ Other_____

10. Recommendations:

☒ Recommend for licensure in Massachusetts.

☐ Recommend for licensure in Massachusetts, with the following reservations:

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

Signature of Evaluator: GSawin, MD, MPH (check one) ☒ M.D. or ☐ D.O.

Name of Evaluator (Printed): Gregory Sawin, MD, MPH Date: 2 / 2 / 2018

Title/Position: Program Director

E-mail address: gsawin@challiance.org Phone number: 781-338-0550

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

CHECKLIST FOR APPLICATIONS FOR BOARD

Applicant Last/First Name: Dhadvai Karthi
LIC#: 27417 ☐ Name Change Documents _____
☑ LIMITED License # 24746

APPLICATION **HOLD APPLICATION** _____
☑ CORI Form ☑ U.S. ☐ IMG ☐ OFF-SHORE
☑ 90 Day Form ☐ FCVS

☑ Pg 1: NPI #, Mailing/ Home/Business Address, DOB, SS#
☑ Pg 2: Med Ed/PG, Pg 3 Exam ☑ Pg 4 Q. 1 Q.4, Signature & Date
☑ Pg 4 Opioid Pain Management ☑ Pg 4 Child Abuse and Neglect
☑ Authorization Form ☑ EHR Proficiency Form
☑ CV (Mo/Year) ☑ No Gaps or Gaps
☑ Name & Addresses Match CLARIS
☑ Child Abuse Training Entered in CLARIS
☑ EHR Proficiency Selection in CLARIS

SUPPLEMENT FORMS
☑ All Questions Answered: _____(Yes)
☐ Explanation for "Yes" Questions
☐ Questions Entered in CLARIS
☑ Dated, Signed, Current

MORAL AND PROFESSIONAL FORM
☑ Color Photo, Signed, Dated, Notarized
☑ Years Known Applicant (1 yr U.S./IMG)

MEDICAL SCHOOL Form B Limited Lic Appl
☑ Dates MO/DAY/YR, Degree Date, Total Weeks/Months (U.S./IMG)
☐ J Waiver Request/E1 and E2 and Evaluative Files
☑ 4 Years U.S. /6 Years IMG/Medical Education over Explained
☑ Questions Answered, Yes Explanations
☑ Signatures of Dean, Seal Affixed ☑ Transcripts in English
☐ Med School Dates Match CLARIS

EXAMINATION SCORES
☑ Exams Passed in 7 Years ☐ Step III Passed After Third Attempt
☐ Exams Passed over 7 Years ☐ Waiver Letter /Evaluative Files
☑ Exams Listed in CLARIS

ECFMG STATUS REPORT
☑ N/A ☐ Stamped "Valid Indefinite"

STATE LICENSE VERIFICATION LETTERS
☑ N/A ☐ Received From All States
☐ Licenses Listed in CLARIS

POSTGRADUATE TRAINING FORMS
☑ "Program Type", Dates MO/DAY/YR, "Completed" Column
☑ 2 Years U.S. /3 Years IMG & Offshore Accredited Training
☑ Questions Answered, Signed, Seal Affixed
☑ Evaluative Files ☐ Research/Gap Letters Received
☑ Training Dates in CLARIS Match Postgrad Verification

SUPERVISORY EVALUATION FORMS and or 3 LETTERS
☑ 1 Year US and IMG / 2 Years Locum Tenens
☑ Completed- "From" and "To" Dates
☐ Signed/Dated and Current
☐ Question 5 Below/Poor
☑ Questions 2 and 4 answered ☐ Evaluative Files Received
☑ **AMA/AOA** ☑ **NPDB** ☑ **FED CHECK**

MALPRACTICE HISTORY FORMS/REPORTS Current
☑ N/A ☐ Form Signed, Dated ☐ Reports

☐ **Checklist Completed**

☐ **OTHER:** _____

ANALYST: Kathy Reviewer: Gina
DATE REVIEWED: 4/5/18 DATE
COMPLETED: ___/___/___ BOARD
APPROVAL DATE: ___/___/___
☐ Director Review ☐ Legal ___/___/___
L:\Full License Applications\Full Instructions Folder

Gentile, Gina (MED)

From:	Linehan, Kathleen (MED)
Sent:	Thursday, March 29, 2018 11:59 AM
To:	Gentile, Gina (MED)
Subject:	Kanthi Dhaduvai 274147

Kanthi Dhaduvai is ready for review 274147.

Thanks!

Kathy Linehan
Licensing Analyst
Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Kathleen.linehan2@massmail.state.ma.us

CHECKLIST FOR APPLICATIONS FOR BOARD

Applicant Last Name: Dhaduvai
LIC#: 274147 ☐ Name Change Documents
☒ LIMITED

APPLICATION
☒ CORI Form ☒ U.S. ☐ IMG ☐ OFF-SHORE
☒ 90 Day Letter ☐ FCVS

☒ Pg 1: NPI Number, Mailing and Home/Business Address Listed
☒ Pg 2: Med Ed & PG Listed ☒ Pg 4 Q. 1 Q.4, Signature & Date
☒ Opioid and Pain Management ☒ Child Abuse and Neglect
☒ Authorization Form ☒ EHR Proficiency Form
☒ CV (Mo/Year) ☒ No Gaps
☒ Name & Addresses Match CLARIS
☒ Child Abuse Training Entered in Demographics
☒ EHR Proficiency Selection in CLARIS

SUPPLEMENT FORM
☒ All Questions Answered: _____(Yes)
☐ Explanation Boxes for "Yes" Questions
☐ Questions Entered in CLARIS
☒ Dated and Signed

MORAL AND PROFESSIONAL FORM
☒ Photograph, Signed, Dated and Notarized
☒ Years Known Applicant (1 yr U.S./IMG)

MEDICAL SCHOOL
☒ Dates MO/DAY/YR, Degree Date
☒ Total Weeks/Months (U.S.)
☒ >4 Years U.S. / > 6 Years IMG Explained
☒ Questions Answered, Yes Explanations
☒ Signatures of Dean, Seal Affixed ☒ Transcripts in English
☒ Med School Dates Match CLARIS Demographics

EXAMINATION SCORES
☒ Exams Passed in 7 Years ☐ Step III Passed After Third Attempt
☐ Exams Passed over 7 Years ☐ Waiver /Evaluative Files Received
☒ Exams Listed in CLARIS

ECFMG STATUS REPORT
☒ N/A ☐ Stamped "Valid Indefinite"

STATE LICENSE VERIFICATIONS
☒ N/A ☐ Received From All States Where Active
☐ Licenses Listed in CLARIS

POSTGRADUATE TRAINING
☒ "Program Type", Dates MO/DAY/YR, "Completed" Column
☒ 2 Years U.S. /3 Years IMG & Offshore Accredited Training
☒ Questions Answered, Signed by Program Director
☒ Seal Affixed ☐ Research Letters Received
☒ Training Dates in CLARIS Match Postgrad Verification

EVALUATION FORM
☒ 1 Year US and IMG / 2 Years Locum Tenens
☒ Completed- "To" and "From" Dates
☒ Signed & Dated by M.D.-Program Director / or Department Chief in Same Specialty ☐ Below/Poor Evaluations
☒ Current; Not Expired ☐ Evaluative Files Received

☒ **NPDB** ☒ **AMA** ☒ **FED CHECK**

MALPRACTICE HISTORY FORM
☒ N/A ☐ MPF Signed & Dated ☐ Malp Hist Rpts

☒ **Checklist Completed**

☐ **OTHER:** _____

ANALYST: KL Reviewer: _____
DATE REVIEWED: ____/____/____
DATE COMPLETED: ____/____/____
BOARD APPROVAL DATE: ____/____/____
☐ Director Review ☐ Legal ____/____/____
Last Revised 01/21/16 L:\Full License Applications\Full Instructions Folder

From: Linehan, Kathleen (MED)
To:
Subject: Mass medical license update
Date: Thursday, March 29, 2018 12:04:00 PM

Dear Dr. Dhaduvai,

Your application has been forwarded to the review team. I will let you know if anything further is requested.

Thanks!

Kathy Linehan
Licensing Analyst
Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Kathleen.linehan2@massmail.state.ma.us

FULL LICENSE APPLICATION CHECKLIST

Please confirm that all documents listed on this checklist are included with your full license application. All documents from other primary sources must be received in sealed envelopes with the facility seal or signature on the back of the envelope. DO NOT OPEN THE ENVELOPES. Please do not send your full license application to the Board until you have received all of the documents from the primary sources.

Description of Documents Required	Applicant Document Checklist	For Board use only
Check for $600.00 from a U.S. bank or a U.S. money order made payable to the Commonwealth of Massachusetts (application cannot be processed without the licensing fee)	✓	
Full license application – all questions answered and application signed and dated	✓	
Authorization for Release of Information completed	✓	
Electronic Health Records (EHR) Proficiency Form	✓	
90-Day Information Form	✓	
ECFMG Status Report – you must request it to be sent to the Board electronically	N/A	
Questions answered and explanation for "yes" answers or additional documentation in accordance with instructions	✓	
Curriculum vitae listing graduate education, medical school(s), postgraduate training and work history by month and year	✓	
Moral and Professional Character form in sealed envelope	✓	
Medical education verification in sealed envelope	✓	
Postgraduate Verification form(s) completed by postgraduate training program director or authorized agent in sealed envelopes	✓	
Evaluation Form signed by department chairperson, program director or a peer who has supervised or evaluated your clinical activities in sealed envelope	✓	
USMLE, NBME, AOA, LMCC or FLEX examination scores in sealed envelope	✓	
State License Verifications from current and past state license boards where you have held a full license in sealed envelopes (see instructions for Veridoc and state boards that will only send license verifications directly to the Board)	N/A	
AMA (American Medical Association) Physician Profile requested to be sent to Board electronically, or the AOA Osteopathic Physician Profile (sent to you in a sealed envelope)	✓	
National Practitioner Data Bank profile in a sealed envelope	✓	
Original Malpractice History form listing liability carriers since postgraduate training with dates of coverage and policy numbers	N/A	
Malpractice history reports from all liability carriers since postgraduate training listed on your Malpractice History form	N/A	
Malpractice claim report(s) or letter of intent for open or closed malpractice cases from the attorney or liability carrier(s) in sealed envelopes	N/A	
Police report from the police department and court documents from the court or an attorney, if applicable, in sealed envelopes	N/A	
CORI Acknowledgment Form	✓	
Other documents:		
Other documents:		

Please make a copy of your full license application and supplement before sending it to the Board. You are required to provide a copy to every health care facility for credentialing and for enrollment in health plans.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kanthi Dhaduvai, M.D. **License No.:** 274147

Current Status: Active **License Expiration Date:** 4/12/2019

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Malden Family Medicine Center at Cambridge Health Alliance
195 Canal Street
Malden
Massachusetts - 02148
United States of America
(781) 338-0500

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

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
Cambridge Health Alliance	Malden

Physician Name: Kanthi Dhaduvai, M.D. **License No.:** 274147

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/01/2019	12/31/2019	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

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 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?**

25) MassHealth Enrollment Status
I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

Office Based Surgery

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

You indicated that you are a Level I office

Physician Name: Kanthi Dhaduvai, M.D. **License No.:** 274147

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.

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

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

274147

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

REQUEST FOR WALLET CARD

Please explain why you are requesting a wallet card:

- ☐ Lost
- ☒ Never Received
- ☐ Stolen
- ☐ Other _____

I declare under the penalties of perjury that my statement above is true and correct.

Kanthi Dhaduvai — Signature
03/19/19 — Date

PRINT NAME: Kanthi Dhaduvai LICENSE #: 274147

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EMAIL: _____

☒ This is a change of address.

If this is a change of address, please indicate if this change should also be reflected on your home or business address.

- ☒ Home
- ☐ Business

For Office use only

Date Received: 3/19/19 Date Completed: 3/22/19

Completed by: _____

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

RETURN SERVICE REQUESTED

$ 000.50

#
234147

Kanthi Dhaduvai, M.D.

Commonwealth of Massachusetts
Board of Registration in Medicine

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

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

RECEIVED
APR 11 2019
Board of Registration in Medicine

SEND LICENSE VERIFICATION TO: Florida Board of Medicine

ADDRESS: 4052 Bald Cypress Way, Bin C03

CITY: Tallahassee STATE: FL ZIP: 32399-3253

PHYSICIAN'S NAME: Kamin Bhadkamkar

BUSINESS ADDRESS: 45 Lowell Street

CITY: Malden STATE: MA ZIP: 02148

MASSACHUSETTS LICENSE NUMBER: 237457

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: 3/19/19

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