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

Physician Registration Renewal Application

RECEIVED MAR 25 1999 Board of Registration in Medicine

RECEIVED MAR 18 1999 Board of Registration in Medicine

Before proceeding, please read the instruction booklet.

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

Registration No.: 59447 Renewal Date: 05/19/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
BETSY S AUGUST, M.D.
SALEM WOMEN'S HLTH ASSOC
331 HIGHLAND AVENUE
SALEM, MA 01970

B) Home Address:

Home Phone:
Business Phone: (978)741-3700

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

5. A) Name of Medical School:
Brown University School of Medicine

B) Year Graduated: 1984 C) Degree: MD

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

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

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: 400 Highland Ave.
City/Town: SALEM State: MA.
Zip: 01970 Country: USA

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

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

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	40 hours
___ ___ ___	
If OS, Print Specialty:	

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: MA 0383567 R

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

Abbr: N H ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: AUGUST Registration Number: 59447

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

Facility Code: 141 (AP) 95 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

Facility Code: 168 (AP) 5 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

If 999, print name(s): ___

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

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

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

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

Please explain exemption: ___

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

13. A. What is your principal work setting? (See Table 4) 2 0

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

1) Average weekly hours involved in: a) outpatient care 32 hrs/wk b) inpatient care 8 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

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

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

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

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

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

Signature: Betsy August Date: 3/16/99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

PRINT NAME AND NUMBER: Last Name: AUGUST Registration Number: 59447

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

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

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Betsy August Date: 3/16/99

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

♻

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

mr 4-17

Before proceeding, please read the instruction booklet.

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

Registration No.: 59447 Renewal Date: 05/19/97

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

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

3. A) Mailing/Business Address:
BETSY S AUGUST, M.D.
SALEM WOMEN'S HLTH.ASSOC
331 HIGHLAND AVENUE
SALEM, MA 01970

B) Home Address:

Home Phone:
Business Phone: (508)741-3700

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 05/18/88 D) SS#:

5. A) Name of Medical School:
Brown University, Program In Medicine
B) Year Graduated: 84 C) Degree: MD

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

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

Corrections (type or print)

Other Name(s): _____

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

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

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

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

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

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

Abbr: ____ ____ ____ ____
Abbr: ____ ____ ____ ____

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

LLS

PRINT NAME AND NUMBER: Last Name: AUGUST Registration Number: 59447

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

Facility Code: 1 6 8 ✓ (AP) Facility Code: ___ ___ / ___ (AP) Facility Code: ___ ___ / ___ (AP)
Facility Code: 1 4 / ✓ (AP) Facility Code: ___ ___ / ___ (AP) Facility Code: ___ ___ / ___ (AP)
If 999, print name(s): _____

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

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

If 999, write Name(s): _____

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

Name of Insurer: PROMUTUAL

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 2 0

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

1) Average weekly hours involved in: a) outpatient care 32 hrs/wk b) inpatient care 48 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 40 %

PART A

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

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption	☒	☐

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

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

Signature Betty August MD Date: 4/9/97

PRINT NAME AND NUMBER: Last Name: AUGUST Registration Number: 59447

PART B CONFIDENTIAL MEDICAL INFORMATION

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

IN THE PAST TWO (2) YEARS	YES	NO

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

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

Treating Organization: _____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

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

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

Signature Betty August MD Date: 4/9/97

Print Name: Betsy August
License Number: 59447

Supplementary Questionnaire

Physicians are requested to provide the following additional information relating to their practice and education

If your practice includes more than the two areas of specialty or sub-specialty about which you have previously told us in your renewal application, please list them here. (If Board Certified, include only ABMS Boards or Sub-Boards) Please list your primary specialty first. Please use codes from the enclosed specialty codes list.

Specialty	Board Certified (Y/N)	Specialty Board or Sub-Specialty Certificate

Please list below your post-graduate medical training, including the beginning and ending dates for each, as well as a description of the training or appointment. (i.e. Internship, Residency, Fellowship, etc.) Please include the full month, day, and year for the beginning and ending of each. (No CVs, please.)

Training Site/Location	Start	End	Description of Training
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Massachusetts Physician Profiles

As many of you are aware, in 1996, the Legislature passed, and the Governor signed, a bill requiring the Board to provide a written profile of Massachusetts physicians to consumers upon request. A profile of each doctor is maintained by the Board for this purpose. When your application for renewal has been approved by the Board, a copy of your profile will be mailed to you, and you will be given an opportunity to correct any factual errors which it may contain before it is made available to the public. When you receive your profile in the mail you will see a notation that it cannot be released to the public before a certain date. This "hold period" will enable you to respond to the Board to make any appropriate corrections or additions. Responses may be made by mail, fax, or phone call to the Physician Profiles office at the Board. Subsequent to this "release date," your profile will be available to the public.

Your application for renewal contains several addresses. Your profile will be mailed to the address which you indicate is your place of business. If you wish Profiles correspondence to be sent to a different address, please notify the Profiles office of your preferred address.

You may obtain a copy of your profile at any time from the Profiles office, (617) 727-3086. Changes, additions, or deletions may be made whenever needed during the year, FAX to (617) 357-8453.

I. PHYSICIAN INFORMATION

BETSY	S	AUGUST	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 59447
License Status Active

First Issue Date 05/18/88

Hospital Affiliation

Salem Women's Hlth.Assoc
331 Highland Avenue
Salem, MA 01970
U.S.A.
(508) 741-3700

North Shore Medical Center-Salem Hosp
Massachusetts General Hospital

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☒ Yes ☐ No

Accept Medicaid? ☐ Yes ☐ No

II. EDUCATION & TRAINING

Brown University, Program In Medicine	MD	84
Medical School	*Degree*	*Date*

Make corrections here

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

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

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

.....

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. AUGUST

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

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

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

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

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

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

Registration No.	Status	Fee	Renewal Date	Late Fee
59447	ACTIVE	$250.00	05/19/95	$25.00

Mailing Address:

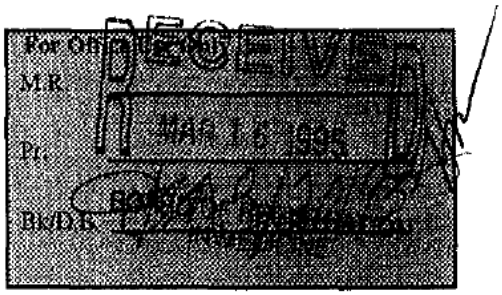
BETSY S AUGUST, M.D.
SALEM WOMEN'S HLTH.ASSOC
331 HIGHLAND AVENUE
SALEM, MA 01970

Correction of Mailing Address

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

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

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



Pre-Printed Information

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

2. Home Address:

3. Date of Birth: Sex: F
   Lic. Issue Date: 05/18/88 SS#:

   Home Phone: Business Phone: (508)741-3700

4. Name of Medical School:
   Brown University, Program In Medicine
   Year Graduated: 84 Degree: MD

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

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

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

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

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

Corrections of Pre-Printed Information

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

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

Home: Business: ( ) _____

Full Name of Medical School: _____
_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

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

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: AUGUST Registration Number: 59447

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

Facility Code: 014 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 168 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

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

Facility Code: 168 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

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

List Insurer: JUA Medical Malpractice

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

State how otherwise exempt: _____

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

13. a) What is your principal work setting? (See Table 4) 15

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

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 45 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 20 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 25 %

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

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

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

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

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

Signature: Beth Augustine Date: 3/13/95

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

Registration No.	Status	Fee	Renewal Date	Late Fee
52447	ACTIVE	$250.00	05/19/93	$25.00

Mailing Address:

LETSY S AUGUST, M.D.
SALEM WOMEN'S HLTH.ASSOC
351 HIGHLAND AVENUE
SALEM, MA 01970

Correction of Mailing Address:

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

Directions: Staple check to bottom of form. Add late fee if necessary.

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

For Office Use Only
M.R. MAY 17 1993
Pr. 3 MAY 17 1993
Bk/D.E. 5-12-93 OK

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   SALEM WOMEN'S HLTH.ASSOC
   351 HIGHLAND AVENUE
   SALEM, MA 01970

3. Date of Birth: Sex: F
   Lic. Issue Date: 05/16/88 SS#:
   Telephone Number:
   Home Business
   (503)741-3700

4. Name of Medical School:
   Brown University, Program In Medicine
   Year Graduated: 84 Degree: MD

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

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

Code	Hours per Week in Mass.	
030	0	Obstetrics and Gynecology
	0	

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: 05 Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

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

Corrections of Pre-Printed Information

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

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

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

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

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

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

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

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: AUGUST Registration Number: 59447

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

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

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

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 1 4 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: 9 9 9 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
If 999, write name(s): North Shore Community Health Center, PEABODY MA

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

14. a) What is your principal work setting? (See Table 5) 2 0

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 60 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 10 hrs/wk in MA

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

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

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

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

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

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

Signature: Betsy August MD Date: 3/18/93

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

Registration No.	Status	Fee	Renewal Date
59447	ACTIVE	$150	05/19/91

Dr. BETSY S AUGUST
39 WALNUT STREET
PEABODY, MA 01960-

RECEIVED MAR 1991

For Office Use Only
M.R. ____ / /
Pr. ____ / /
Bk. MAR 2 2 1991 / /
Ch. ____ / /
D.E. VR 4/9/91

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

Activity Status:
I am applying to be registered with the following status: Active ✓ Inactive ____
I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

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

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

Name: ____

2. a) Address (Home):

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

2. b) Address (Business):
~~39 WALNUT STREET~~
PEABODY, MA 01960-

Address: 150 MAIN STREET
City/Town: ____
State: ____ Zip: ____
Country Code: ____ (if 999, write Country): ____

3. Date of Birth: Sex: F
Lic. Issue Date: 05/18/88 SSN
Telephone Number:
Home Business
(508)532-4903

Date of Birth (M/D/Y): ____/____/____ Sex (M/F): ____
Lic. Issue Date(M/D/Y): ____/____/____ SSN #: ____
Home: (____) ____ Business: (____) ____

4. Medical School Code: RI001 Year Graduated: 84 Degree: MD
Name of School:
Brown University, Program In Medicine

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

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

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

Code	Hours per Week in Mass.	
~~065~~	~~0~~ 0	~~Obstetrics~~

Code	Hours per Week in Mass.
OBG	one hundred

If OS, write specialty: ____

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

Code: OG
Code: ____

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) ____ b) How many DEA nos. do you have? 1
c) State (MA) #M ____

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

30M - 9/90 - P813971

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

FILL IN NAME AND NUMBER:

Physician Last Name: AUGUST Registration No.: 59447

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

List Insurer: Dreyfus, Rice and Getter, JUA

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

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

(State how otherwise exempt):_____

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

Facility Code: 014/M (AP) Facility Code: ____/__(AP) Facility Code: ____/__(AP)

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

If 999, write Name(s):_____

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

Facility Code 339 Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write Name(s):_____

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

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

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

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

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

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 8+ hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 16 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? *(See Table 6)* 25

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

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

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

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

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

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

Signature: Betsy S August MD Date 3, 15, 91

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

008602

Board Use Only:

Registration No.	Status	Fee	Renewal Date
59447	1	$150	05/19/89

BETSY S AUGUST
39 WALNUT STREET
PEABODY, MA 01960

M.R. CC
Pr. CC 3/24/89
Bk. CC 3/30/89
Ch.
D.E. JA 4/4/89
Fl.

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

1. a) Name (LAST:) AUGUST (FIRST:) BETSY (M.I.:) S.

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

2. a) Address (Mailing): 39 Walnut ST.
Peabody, MA. 01960

2. b) Address (Home):

2. c) Address (Business): 39 Walnut ST.
Peabody, MA. 01960

2. d) Telephone (Business): (508) 532-4903 Extension 2. e) Telephone (Home) *(Optional)*: (

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

6. a) Medical School Code *(See Table 1)*: RI001 *If 99999, write* Name:

6. b) Year Graduated: 1984 6. c) Degree: M.D. ✓ D.O.

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

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

10 Hospital	10 %	15 Private Office	%	20 Partnership/Group Practice	%
25 Clinic	90 %	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	%	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

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

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	90 %
30 Administrative Activities	%	40 Medical Teaching	10 %
50 Medical Research	%	99 Other	%

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 5/18/88

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

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

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

RECEIVED MAR 1989

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated, Percent of Practice Time at each. *(See Table 4.)*
Facility Code: 014 100 % Facility Code: % Facility Code: %
Facility Code: % Facility Code: % Facility Code: %

If 999, write Name(s):

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

If 999, write Name(s):

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

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

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

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

Signature: Betsy August M.D. Date: 3/24/89
(see reverse side)

Fill in name and number. **Physician Last Name:** AUGUST **Registration No.:** _____

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

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

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

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: _____ hrs., Category II: _____ hrs., (Risk-Management: _____ hrs.); Residency Program in: 1988
Waiver Requested ___ (You must fill out a separate Waiver Form.)

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

14. c) Percent of Practice Time in Massachusetts: 100 %

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

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

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

****

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

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

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

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

Circumstances of restriction: _____

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

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary.*
Treating Organization: _____ Telephone: (___) ___-____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

Dates of Illness/Dependency: ___/___/___ to : ___/___/___ Dates of Treatment: ___/___/___ to : ___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary.*
Organization: _____

Date: ___/___/___ Action: _____

Circumstances leading to loss of certification or denial of recertification: _____

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

If the candidate has attended more than one medical school, additional verification of the medical instruction in the other school will be required.

Date: 2/18/88 19___

I hereby certify that Betsy S. August

has attended 4 years of instruction of not less than thirty-two weeks in each year in

Brown University Program in Medicine

(give name of medical school)

From: Month	Day	Year	To: Month	Day	Year
9	15	80	6	1	81
8	20	81	6	1	82
8	2	82	7	31	83
8	1	83	5	28	84

AND HAS RECEIVED THE DEGREE OF Doctor of Medicine on May 28 19 84

from Brown University, Program in Medicine

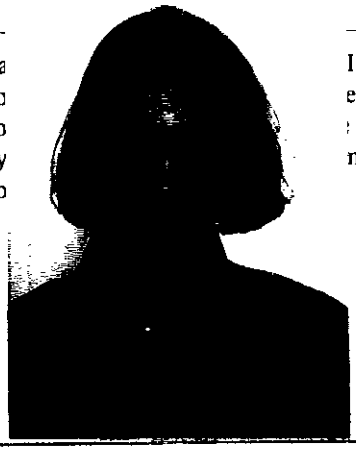
(give name of medical school)

School Seal

Ruth B. Sauber

Ruth Sauber *Signature of Dean*

Student Affairs Officer



Pa... If im-
po... ean of
yo... done
by... m the
ap...

Betsy August MD

signature of applicant

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

Ruth B. Sauber

signature of Dean, Registrar, or Notary

(expiry date of commission, if applicable)

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

This certificate must be signed by a physician legally authorized to practice medicine. If said physician is registered outside of Massachusetts, the NUMBER of his certificate of registration MUST be given.

Date: 2/19 19 88

This certifies that I have been personally acquainted with Betsy Avoua MD of 89 Harrison St, Northampton for 4 years; that I believe her to be of good moral and professional character, and in every respect worthy of confidence, I hereby recommend her to the Massachusetts Board of Registration and Discipline in Medicine.

[signature] MD

Dept of OB/Gyn / Baystate Medical Center
759 Chestnut Street, Spfd, MA. 01199 *address*

30576 Massachusetts

license # *State*

All information included in this application for licensure constitutes a true statement made under penalty of perjury.

Betsy August MD

(signature of applicant)

AFD

88-00464

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved:
Disapproved:

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

Filed: 2/24/88
By: Pg
Form of Fee: m.o.

FOR OFFICE USE

Application # 63746
Certificate # 59447 Date of Issue: 5/16/88

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name: Betsy S. August
First Last

Mailing Address:

Date of Birth

Place of Birth

Name on Birth Certificate Betsy Sue August

Phone #

Pre-medical Education Program in

School Brown University, medicine

Dates Attended September 1976 – June 1980

Medical Education

School Brown University Program in Medicine

Dates Attended July 1980 – June 1984

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

Place	Position	Dates
BAYSTATE Medical Center	Resident Obstetrics and Gynecology	July 1984 – June 1988

List all other states where you are or have been licensed: none

Are you a Diplomate of a Specialty Board? No.
(name, if applicable)

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

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

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Barry S Auguste

PERMANENT ADDRESS:

LOCAL MAILING
ADDRESS IN (MA):

HOSPITAL: Baystate Medical Center

ADDRESS: 759 Chestnut St
Springfield MA. 01199

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

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

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

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

SIGNATURE: Barry Auguste MD DATE: 12/14/87

59447

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

617/727-3086

To all Applicants

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

I, Betsy August MD
Name

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

Date: 12/14/87

Betsy August MD
Signature

Social Security Number, Optional

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

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

Date: 12/14/87

Betsy August MD
Signature

BROWN UNIVERSITY *Providence, Rhode Island • 02912*

September 1, 1987

To Whom It May Concern:

This is to certify that Betsy Sue August attended Brown University from September 1976 to May 1984. Ms. August graduated, receiving a Bachelor of Science degree on June 2, 1980 and a Doctor of Medicine on May 28, 1984. She completed all of the pre-medical requirements usually required by American medical schools as part of her undergraduate work at the University.

Sincerely,

Katherine P. Hall

Katherine P. Hall
Registrar

KPH/mh

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

April 27, 1988

Mary E. Cobbett
Medical Staff Office
Salem Hospital
81 Highland Avenue
Salem, MA 01970

Dear Ms. Cobbett:

Enclosed please find a copy of Dr. Betsy August's application for licensure to the Board of Registration in Medicine. Dr. August's application is pending at this time.

It is very likely that Dr. August's application will be acted upon within the coming month. As you may know, the licensure process is a lengthy one, and it is not unusual for processing and review to span several months.

If there is anything else you need in terms of application materials, you may contact me at the above phone number.

Sincerely,

Tami Sobel
Licensing Attorney

Carolyn —
Please put
in Dr. August's
file

Thank —
Tami

TS/nm
Enclosure
bcc: Dr.
Overnight

A + F

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE 59449/5-18-88

APPLICATION FOR ~~LIMITED REGISTRATION~~ AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks) L 2948

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.

FOR OFFICE USE
Date Received 3-5-87
Certificate # 91053
By: K.W. Form of Fee: M.O.

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: Betsy (First) Sue (Middle) August (Last)
Date of Birth:

Mailing Address:

Pre-medical School: Brown University

Medical School: Brown University Program in Medicine

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? yes 88174 (give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?	1.	
2.	Have you ever been denied a medical license?	2.	
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	
4.	Have you ever failed an examination before a State Medical Board?	4.	
5.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?	5.	
6.	Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff?	6.	
7.	Have you ever been a patient for the treatment of a mental illness?	7.	
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Betsy August MD DATE: 12/30/86

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that Betsy Sue August has been appointed to the position of PGY-4 Hospital Medical Officer in Baystate Medical Center (Name of Hospital)

beginning July 1, 1987 and ending June 30, 1988.

Is the purpose of this application participation in a training program? yes (yes or no)
If yes, is this program ACGME or RRC accredited? yes (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? _____ (yes or no)

Ethel Weinberg
SIGNATURE Ethel Weinberg, M.D.

Vice President, Academic Affairs
OFFICIAL CAPACITY

2/24/87
DATE

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

To be completed only if you attended college outside of the United States, Canada or Puerto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION
(to be completed ONLY by the Dean of the School)

Date _____ 19 ____

I hereby certify that _____ has creditably completed *two years* of a pre-medical course.

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

School Seal

_____
Dean

_____
School

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date _____ 19 ____

I hereby certify that _____ has creditably completed at least *three and one-half years* of medical education.

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

and has received the degree of _____ on _____ 19 ____

from _____
(name of Medical School)

School Seal

_____
signature of Dean

If candidate has attended more than one medical school, additional verification of medical instruction is required.

#620 .../84 - 50 each

Salem Women's Health Associates

Betsy August M.D., F.A.C.O.G. ❖ Luisa Kontoules M.D., F.A.C.O.G. ❖ Stephen Ponchak M.D., F.A.C.O.G.
331 Highland Avenue ❖ Salem, Massachusetts 01970 ❖ 508 741-3700

April 15, 1993

Docket Administrator
Disclipinary Unit
Board of Registration in Medicine
Ten West Street
Boston, MA 02111

RE:
Complaint # 93-104

Dear Sir:

Enclosed you will find the letter from Robert J. Ward of the Massachusetts Medical Society which I received on 12/24/92. I also enclosed my letter to Dr. Ellis in response to the complaint. The Medical Society reviewed her complaint about the cost of her tests, and asked us to reduce her bill. Our office manager spoke with MetPath billing as requested and they agreed to discount her for the remaining balance. I enclose my letter to Ms. She never once came to our office after her visit to ask us what could be done for her or to review her tests with her.

I will await your disposition of her complaint.

Sincerely,

Betsy August

Betsy August, M.D.

BA/jb

enclosure

Salem Women's Health Associates

Betsy August M.D., F.A.C.O.G. ❖ Luisa Kontoules M.D., F.A.C.O.G. ❖ Stephen Ponchak M.D., F.A.C.O.G.
331 Highland Avenue ❖ Salem, Massachusetts 01970 ❖ 508 741-3700

January 11, 1993

Daniel S. Ellis, M.D.
Massachusetts Medical Society
1440 Main Street
Waltham, MA 02154-1649

Dear Dr. Ellis:

This letter is in response to the complaint brought by .

The patient brings up several issues which I will address. The first issue was Ms. claim that her problem has been of short duration. In reality, her problem has been longstanding since 1990. She was seen by Dr. at his former office for irregular bleeding. In addition, her blood pressure had been labile. I did not see any labwork from his previous exams. She saw him in this office '91, again with irregular bleeding. Her first visit with me for this problem was on 92. On that day, she did not have hot flashes, vaginal dryness, nor irritability. I examined her and did her annual checkup. I discussed the literature that our nurse had sent her on 92 concerning the menopause. I explained that although I was questioning the menopause, there were other reasons for amenorrhea to evaluate. I always ask patients if they have any questions.

Metpath is the lab which draws blood in our office. They do not pay us rent, nor do we get any profits from lab work drawn. They are a part of our office solely as a convenience to our patients. Patients save time and frustration by not having to travel to Salem Hospital for their labwork. Metpath offers a discounted rate to patients who do not have insurance nor money. The can also arrange to pay what they can on a scheduled basis. Patients can ask for help when needed. Metpath also offers a discounted "package" for bloodwork drawn for profiles such as pregnancy and amenorrhea. The cost is less than the individual items alone. My evaluation included FSH, LH, estradiol, prolactin, and a thyroid panel. I considered adrenal function due to fluctuations in blood pressure, body habitus and hair pattern.

Ms. is a very verbal, intelligent woman. At any time throughout her medical care she was able to ask for the rationale behind her workup as well as state her financial needs. Our office makes every attempt to be of service to our patients. If she did not ask for more information, it was not because she was not given the opportunity.

Thank you.

Sincerely,

Betsy August M.D.

Betsy August, M.D.

BA/jb

Salem Women's Health Associates

Betsy August M.D., F.A.C.O.G. ❖ Luisa Kontoules M.D., F.A.C.O.G. ❖ Stephen Ponchak M.D., F.A.C.O.G.
331 Highland Avenue ❖ Salem, Massachusetts 01970 ❖ 508 741-3700

April 15, 1993

Ms.

Dear :

I am sorry you have been dissatisfied with your medical care at our office. Since receiving your carbon copy letter to MetPath dated 11/12/92, I have not had any phone calls from you. I am responding to your complaint which I received by means of a letter from the Massachusetts Medical Society. You would have had a more prompt response had you contacted me by letter or phone directly rather than go through a third party.

Your laboratory tests have been reviewed with MetPath and they have been asked to reduce your bill. Our Office Manager, , phoned and left a message on your answering machine on April 13, 1993. We wanted to inform you that you would not be billed for any balance not covered by your insurance. To this date, you have not returned Joanne's call.

For your convenience alone were laboratory tests drawn at this office. Our office never **receives** any monetary reimbursement from the laboratory. They are not charged for the use of the space. We have modified our procedure, and effective May 1, 1993, all of our laboratory testing will be done at Salem Hospital. Unfortunately, this will be a bit of an inconvenience for our patients as they will have to make an extra trip. We do not wish to have any misconceptions about our practice, despite the inconvenience for the majority of our patients.

As for the cost of laboratory tests, everyone who comes to the office is able to tell us whether or not their insurance company covers bloodwork and cultures. You had the opportunity to ask questions and to review all of the tests ordered with me. If you do not ask questions at the time of your visit, you can always call us or write them down. We cannot read your mind nor can you expect us to know what is bothering you unless you contact us.

I hope in your future relationships with physicians you go directly to them so that you can get the best communication and care. I will forward this letter both to the Massachusetts Medical Society and to the Board Of Registration in Medicine.

Sincerely,

Betsy August, M.D.

pc: Board of Registration
in Medicine

Massachusetts Medical Society

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

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 9, 1993

Betsy S. August, M.D.
Salem Women's Health Associates
331 Highland Avenue
Salem, Massachusetts 01970

Re: Complaint No. 93-104

Dear Dr. August:

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

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

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

Very truly yours,

Mary F. McGonagle

Mary F. McGonagle
Docket Administrator

Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 1, 1993

Betsy S. August, M.D.
39 Walnut Street
Peabody, Massachusetts 01960

Re: Complaint No. 93-104

Dear Dr. August:

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

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

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

Very truly yours,

Mary F. McGonagle
Docket Administrator

Enclosure

Salem Women's Health Associates

Betsy August M.D., F.A.C.O.G. ❖ Luisa Kontoules M.D., F.A.C.O.G. ❖ Stephen Ponchak M.D., F.A.C.O.G.
331 Highland Avenue ❖ Salem, Massachusetts 01970 ❖ 508 741-3700

April 28, 1993

Docket Administrator
Disclipinary Unit
Board Of Registration in Medicine
Ten West Street
Boston, MA 02111

RE:
Complaint #93-104

Dear Sir:

Enclosed you will find a copy of a letter sent tc by me. Under the circumstances, I feel that it is best to end the physician-patient relationship.

Please call my office if you have any questions.

Thank you.

Sincerely,

Betsy August

Betsy August, M.D.

BA/jb

enclosure

Salem Women's Health Associates

Betsy August M.D., F.A.C.O.G. ❖ Luisa Kontoules M.D., F.A.C.O.G. ❖ Stephen Ponchak M.D., F.A.C.O.G.
331 Highland Avenue ❖ Salem, Massachusetts 01970 ❖ 508 741-3700

April 28, 1993

Ms.

Dear :

Thank you for your letter dated April 24, 1993. There is no need to engage in angry letter writing. In response to your statements, I can only say that patients are allowed to ask for financial help from our office as well as from any of the laboratory and ultrasound services used by the office. They still get the tests done that they need done and our office goes a long way to ease financial burdens wherever possible.

I believe it is best for us to not continue with our relationship as physician and patient due to our mutual concern for quality of care and communication. I understand you have sought consultation with another physician and I hope you will be more comfortable with that person. Our office is happy to send your records and to cover any emergencies during the next month while you are establishing yourself with that practice.

I wish you well in the future.

Sincerely,

Betsy August

Betsy August, M.D.

BA/jb

pc: Board of Registration
in Medicine
Massachusetts Medical Society

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

June 3, 1993

Betsy S. August, M.D.
Salem Women's Health Associates
331 Highland Avenue
Salem, Massachusetts 01970

Re: Docket No. 93-104

Dear Dr. August:

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

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please feel to call me at 617-727-1788, ext. 310 or write to the above address.

Very truly yours,

Peter Clark
Director of Enforcement

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

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

June 3, 1993

Re: Betsy S. August, M.D.
Docket No. 93-104

Dear Ms. ! :

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

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

Should you have any questions or additional material which you wish the Board to consider, please write to the Docket Administrator at the above address. I regret that the Board does not have sufficient staff to respond to telephone inquiries regarding complaints.

Very truly yours,

Peter Clark
Director of Enforcement

April 24, 1993

Dr. Betsy August
Salem Women's Health Associates
331 Highland Avenue
Salem, MA 01970

Dear Dr. August:

I would like the opportunity to respond to your letter dated April 15 because there are several issues that need to be set straight:

- When I initially received the bill from MetPath, I call your office immediately. You were unavailable, so I spoke to a woman named . I expressed my concern about the bill and all the tests that were ordered and asked to have you call me. You thereafter left a message on my answering machine stating my need for an estrogen test. I never questioned the need for an estrogen test--it was the other $700 worth of tests I questioned. I called your office several times over the next week in an attempt to discuss this with you personally and got no response. It was only after my ensuing phone calls were ignored that I decided to seek the help of a third party.

- The test results were entirely wrong. I don't know if you inadvertently passed on to me the results of someone else's tests or if the lab made an error. However, after you told me to come in for a sonogram (and possibly later for a biopsy) because of the possibility of cancer due to the high reading, I sought the assistance of another doctor. That doctor called MetPath requesting the results of the tests you ordered. He felt that the results of the estrogen test were extraordinarily high and he took the test again, twice. Both the second and third test results showed that I am indeed in the menopausal stages--not in need of testing for the possibility of cancer.

- When I returned vesterday from my 15-day vacation yesterday, I had the April 13 message from on my telephone answering machine. I did in fact return s call this morning only to learn that she is on vacation. Her call wasn't ignored; I was out of town.

- You mention that I had the opportunity to discuss the tests at the time of my visit because you cannot read my mind or know what I expect. *Shame on you for being so flippant.* You told me that you needed to check my estrogen level, and I was in complete agreement. I had no reason to expect that you would order a battery of tests that were unnecessary. Had I thought you were that kind of doctor, I would not have sought your services in the first place.

- Finally, you mention "...everyone who comes to the office is able to tell us whether or not their insurance company covers bloodwork and cultures." This indicates to me that the availability of insurance may be a factor in your determination of which blood tests are ordered. If a patients needs tests, the tests should be performed for the well being of the patient. Insurance coverage is not a license to be abusive.

I am pleased that you and the lab will not hold me responsible for any balance not covered by the insurance company because there is no reason I should have to pay for tests I did not need.

Sincerely,

cc: Board of Registration in Medicine
Massachusetts Medical Society

April 4, 1993

Complaint Department
Board of Registration in Medicine
Ten West Street
Boston, MA 02111

Dear Sir or Madam:

Re: Besty S. August, M.D.
Complaint No. 93-104

I had originally contacted you at the suggestion of Mr. Robert Ward of the Massachusetts Medical Society. The Society has since rendered their decision in this matter, and I've enclosed a copy of that decision.

Abuses in the medical profession MUST STOP and it is up to all of us to see that this happens. Thank you.

Sincerely.

Enclosure

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

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 1, 1993

Betsy S. August, M.D.

Re: Complaint No. 93-104

Dear Dr. August:

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

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

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

Very truly yours,

Mary F. McGonagle
Docket Administrator

Enclosure

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

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

April 1, 1993

Re: Betsy S. August, M.D.
Complaint No. 93-104

Dear Ms. :

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

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

Yours very truly,

Mary F. McGonagle
Docket Administrator

December 14, 1992

Division of Insurance
Office of Consumer Affairs
280 Friend Street
Boston, MA 02114

Dear Sir or Madam:

On September 30, 1992, I went to Dr. Betsy August, Women's Health Associates, Highland Avenue, Salem, MA, for my annual check-up. I am 49 years old and for the past two years have experienced a gradual cessation of my menstrual cycle, which at my age is perfectly normal. I asked Dr. August if I could stop using birth control, and she said that she would need to check my estrogen level in order to make that determination.

She lead me to the front of her office where someone drew my blood. I assumed it was one of her nurses. Well, to make a long story short, she ordered a battery of tests, which amounted to $782.50. (A copy of the lab bill is enclosed.) Please refer to the enclosed letter to MetPath for the ensuing events. In response to that letter, a copy of which was sent to Dr. August, she called me and left a message on my answering maching telling me that the estrogen test was necessary. I was certainly not questioning with that test, it was the other ten or eleven.

I have recently come to learn that a person from MetPath did in fact draw my blood, for that person is housed at Dr. August's office. *Isn't that convenient?* **I want to know why these all tests were ordered.**

Very truly yours,

cc: Mr. Robert Ward
Massachusetts Medical Society
1440 Main Street
Waltham, MA 02154

November 12, 1992

MetPath
75 North Mountain Road
New Britain, CT 06053

Dear Sir or Madam:

Re: Patient Account No.

It was an absolute shock to receive a bill from you in the amount of $782.50 for a blood test that was supposed to check my estrogen level. I sent the bill into my insurance company but continued to be troubled by what seemed to be an excessive amount.

I thereafter checked with another lab and with two OB/GYNs to see if tests of this nature are standard procedure to determine a patient's estrogen level. I was told that extensive tests such as these ARE NOT necessary and they are a clear-cut case of abusive overtesting.

I called your lab this morning to find out why there was an $8.00 charge for venipuncture and was told that it was for the blood that was drawn at the lab. No blood was drawn at the lab; it was drawn at the doctor's office a few hundred miles away. The young lady said she would deduct the $8.00 from my bill, but I am wondering *how many other erroneous charges appear on this bill.*

I am also wondering what the doctor did and did not order and whether the tests were mine or were confused with those of another patient. I had the tests retaken by another doctor and the results were dramatically different from the ones you showed.

Something is wrong with this picture!

Very truly yours,

cc: Dr. Betsy August

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

Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.: 59447 Renewal Date: 05/19/2001

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

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

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

3. A) Mailing/Business Address:
BETSY S AUGUST
400 HIGHLAND AVENUE
SALEM, MA 01970

B) Home Address:

RECEIVED
MAR 29 2001
Board of Registration in Medicine

Home Phone:

Business Phone: (781)581-7868

Please make corrections (type or print)

Other Name(s): _____

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

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

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

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

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

c) SS#:

5. a) Name of Medical School:

Brown University School of Medicine

b) Year Graduated: 1984 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) 40 Hours per Week in Mass.

OBG 0 Obstetrics and Gynecology
0

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

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

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

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

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

Facility Code: 537 / ✓ (AP) 95 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 822 / ✓ (AP) 5 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: AUGUST LICENSE NUMBER: 59447

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Controlled Risk Insurance Co. of Vermont Inc. Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No
13. A. What is your principal work setting? (See Table 4) 20
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No ☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption		

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

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

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

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

Signature: Betty Augustus Date: 3/24/01

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

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

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Betsy Augustus Date: 3/24/01

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

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

Physician Registration Renewal Application

RECEIVED
MAR 12 2003
Board of Registration in Medicine

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

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

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

1. Current Status: Active Registration No. 59447 Renewal Date: 05/19/2003

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

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

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

A) Mailing/Business Address:

3. BETSY S AUGUST
400 HIGHLAND AVENUE
SALEM, MA 01970

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (978) 741- 3700

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

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

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

5. a) Name of Medical School:
Brown University School of Medicine
b) Year Graduated: 1984 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

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

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

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

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

Facility Code: 537/ ✓ (AP) 95 % Facility Code: ____/___ (AP) ____% Facility Code: ____/___ (AP) ____%
Facility Code: 168/ ✓ (AP) 5 % Facility Code: ____/___ (AP) ____% Facility Code: ____/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: AUGUST LICENSE NUMBER: 59447

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): CRICO Policy dates: From: 1/1/2003 To: 12/31/2003
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.
☐ Otherwise exempt Please explain exemption:

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

13. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 60 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

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

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.
CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

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

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

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

Signature: Betsy August MD Date: 3/9/03

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

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

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

PRINT NAME AND NUMBER: Last Name: AUGUST License Number: 59447

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

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

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

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

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

Signature: Betty August Date: 3/9/03

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Dr. Betsy S August

License Number: 59447

Data Date

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

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

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

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

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

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

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

☑ My current NPI is: 1 3 4 6 2 3 1 2 7 1

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	Obstetrics and Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: Betsy Augustus Date: 2/2/07

RECEIVED 2007 FEB 20 A 8:31

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

Dr. Betsy S August
400 Highland Ave
Salem, MA 01970

01/31/2007

Dear Colleague:

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

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

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

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

Sincerely,

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

Current Status: Active **License Expiration Date:** 5/19/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
55 Highland Ave
Suite 103
Salem
Massachusetts - 01970
United States of America

Home Address:

Business Address:
55 Highland Avenue
Suite 103
Salem
Massachusetts - 01970
United States of America
(978) 741-2500

3) **Email Address:**

4) **Fax Number:** (978) 741-1146

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**
New Hampshire

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
North Shore Medical Center - Salem Hospital	

Physician Name: Betsy S August, M.D. **License No.:** 59447

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 60 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	12/08/2010	12/08/2011	Occurrence Policy

13) Do you perform any surgery in your Massachusetts office? No

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

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

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

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

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, 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: Betsy S August, M.D. **License No.:** 59447

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.**

Commonwealth of Massachusetts

Board of Registration in Medicine

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

Telephone (781) 876-8230

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: MEDICAL STAFF OFFICE
ADDRESS: BEVERLY HOSPITAL
85 HERRICK ST.
BEVERLY, MA 01915

(TYPE OR PRINT)
PHYSICIAN'S NAME: Betsy August MD

BUSINESS ADDRESS: 55 Higuland Ave Suite 103

CITY: SALEM STATE: MA ZIP: 01970

MASSACHUSETTS LICENSE NUMBER: 59447

SIGNATURE OF PHYSICIAN: Betsy August MD

Signed under the penalties ofperjury

DATE: 3/19/13

This Release shall remain validfor one (1) year from the date of execution

RECEIVED
APR 10 2013
Board of Registration in Medicine

Updated 03/06/2013

Date Received: 4/10/13
Check #: 739279
Check Amount: $ 1000
Initials: CM

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

Current Status: Active **License Expiration Date:** 5/19/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
55 Highland Ave
Suite 103
Salem
Massachusetts - 01970
United States of America

Home Address:

Business Address:
55 Highland Avenue
Suite 103
Salem
Massachusetts - 01970
United States of America
(978) 741-2500

3) **Email Address:**

4) **Fax Number:** (978) 741-1146

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**
New Hampshire

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
North Shore Medical Center - Salem Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	12/14/2012	12/14/2013	Occurrence Policy

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?

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 ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, 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?

Physician Name: Betsy S August, M.D. **License No.:** 59447

22) Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, 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?

Physician Name: Betsy S August, M.D. **License No.:** 59447

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.**

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

LICENSING DIVISION

FAX#: 781-876-8383

FACSIMILE TRANSMITTAL FORM

TO: Janet RE: Dr. Betsy August

FROM: Bertina Counts

DATE: 03/20/2013 **TIME:** _____

FAX#: 978-741-1146

NUMBER OF PAGES INCLUDING COVER SHEET: ____

NOTES: Renewal Copy Response

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

03/20/2013

Dear Janet

The Board cannot send out legal documentation of a physician, in order for Doctor Betsy August to obtain a copy of her most recent renewal, the doctor herself must fax a written request to the board for the copy. Please have her fax a request to me at 781-876-8383- Attention Bertrina Counts (she can indicate who and where she would like the copy sent)

Thank you
Bertrina Counts
Licensing Division
Bertrina.counts@state.ma.us

Betsy S. August, M.D., FACOG

Obstetrics & Gynecology

FACSIMILE TRANSMITIONAL COVER SHEET

PLEASE DELIVER THE FOLLOWING PAGES TO THE ADDRESSEE BELOW AS SOON AS POSSIBLE

TO: Katrina	**FROM:** Janet for Dr. August
COMPANY:	**COMPANY:**
TELEPHONE:	**TELEPHONE:** 978.741.1145
FACSIMILE: 781-876-8383	**FACSIMILE:** 978.741.1146
RE:	**RE:**

DATE: 3/19/13 **TIME:** 3:35 **TOTAL PAGES:** *(INCLUDING THIS COVER SHEET)*

COMMENTS:

DA 594477

Dr. Betsy August failed to keep a copy of her renewal application - would you fax to her office?

978.741.1146

Thank-You so Much Janet for

(She needs to Hosp Credentialing - HELP!!

Betsy August

__Urgent __For Review __Please Comment __Please Reply

Betsy S. August, M.D., LLC

55 Highland Avenue, Suite 103, Salem, MA 01970 · Tel. (978) 741-2500 Fax (978) 741-1146

.T0001072

Commonwealth of Massachusetts

Board of Registration in Medicine

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

Telephone (781) 876-8230

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO:
ADDRESS:

MEDICAL STAFF OFFICE
BEVERLY HOSPITAL
85 HERRICK ST.
BEVERLY, MA 001915

(TYPE OR PRINT)
PHYSICIAN'S NAME: Betsy August
BUSINESS ADDRESS: 9 Colby Street
CITY: Salem STATE: Ma. ZIP: 01970

MASSACHUSETTS LICENSE NUMBER: 53447

SIGNATURE OF PHYSICIAN: Betsy August MD

Signed under the penalties of perjury
DATE: 4/1/14

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

Date Received: 6/6/14

Check #: 7503

Check Amount: $ 10.00

Initials: _____

BETSY AUGUST, MD

BETSY S. AUGUST, MD
OBSTETRICS & GYNECOLOGY
9 COLBY STREET
SALEM, MA 01970
(978)741-2500- PHONE
(978)741-1146- FAX

Only Street Address Has Been Changed

FACSIMILE TRANSMITTAL SHEET

TO: Mass Board of Registration
FROM:
COMPANY: Betsy S. August, MD
DATE: 6/12/15
FAX NUMBER: 781-876-8383
TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:
SENDER'S REFERENCE NUMBER:
RE:
YOUR REFERENCE NUMBER:

(URGENT (FOR REVIEW (PLEASE COMMENT (PLEASE REPLY (PLEASE RECYCLE

NOTES/COMMENTS:

CONFIDENTIAL

Please Note New Address for Dr. August, Lic # 59447
9 Colby St, Salem MA 01970

MA Controlled

Thank you,

Betsy August MD

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

Current Status: Active **License Expiration Date:** 5/19/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America

Home Address:

Business Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America
(978) 741-2500

3) **Email Address:**

4) **Fax Number:** (978) 741-1146

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**
New Hampshire

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** 20 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	12/01/2014	12/01/2015	Occurrence Policy

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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a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
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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?

Physician Name: Betsy S August, M.D. **License No.:** 59447

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.**

Commonwealth of Massachusetts
Board of Registration in Medicine

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

Telephone (781) 876-8230

JOA
80604322

WAIVER FOR RELEASE OF INFORMATION

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(type or print clearly)

SEND LICENSE VERIFICATION TO:
ADDRESS:
85 HERRICK ST.
BEVERLY, MA 001915

MEDICAL STAFF OFFICE
BEVERLY HOSPITAL

(TYPE OR PRINT)
PHYSICIAN'S NAME: Betsy AUGUST
BUSINESS ADDRESS: 9 Colby St
CITY: Salem STATE: MA ZIP: 01970

MASSACHUSETTS LICENSE NUMBER: 59447

SIGNATURE OF PHYSICIAN: Betsy August MD
Signed under the penalties of perjury
DATE: 4/14/16
This Release shall remain valid for one (1) year from the date of execution

Date Received: 5/16/16
Check #: 173992
Check Amount: $ 10.00
Initials: RF

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

Current Status: Active **License Expiration Date:** 5/19/2017

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America

Home Address:

Business Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America
(978) 741-2500

3) **Email Address:**

4) **Fax Number:** (978) 741-1146

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**
New Hampshire

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** 20 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	12/08/2016	12/08/2017	Occurrence Policy

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 no been resolved, settled or adjudicated during this time period?

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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?

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital that has a CMS Meaningful Use program.

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse
Have you completed training to recognize and report suspected child abuse or neglect? Yes

Physician Name: Betsy S August, M.D. **License No.:** 59447

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.

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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.

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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.

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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.

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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.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

Current Status: Active **License Expiration Date:** 5/19/2019

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America

Home Address:

Business Address:
9 Colby Street
Salem
Massachusetts - 01970
United States of America
(978) 741-2500

3) **Email Address:** drbets2004@yahoo.com

4) **Fax Number:** (978) 741-1146

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**
New Hampshire

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** 20 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	12/08/2018	12/08/2019	Occurrence Policy

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?

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.

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.

Physician Name: Betsy S August, M.D. **License No.:** 59447

☒ **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.**

Massachusetts Physician Renewal Application

Physician Name: BETSY S AUGUST **License No.:** 59447

PART A

1) Current Status: Active **Renewal Due Date:** 04/21/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
400 HIGHLAND AVENUE
SALEM, MA 01970

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

RECEIVED
MAR 15 2006
BOARD OF REGISTRATION IN MEDICINE

2c) BUSINESS ADDRESS
400 HIGHLAND AVENUE
SALEM, MA 01970

Phone: (978)741-3700

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 978. 741 - 3354

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

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

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

Massachusetts Physician Renewal Application

Physician Name: BETSY S AUGUST **License No.: 59447**

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

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

Principal Work Setting: Partnership or Group Practice Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 45

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

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Massachusetts General Hospital	☐	Courtesy		2
North Shore Medical Center - Salem Hospital	☐	Admitting		38
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 60 hrs/wk Change to: _____ hrs/wk

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

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

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

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

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

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

Check one:

- ☐ Not involved with direct or indirect patient care in Massachusetts
- ☐ Government Employee Federal Tort Claims Act (FTCA)
- ☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: BETSY S AUGUST **License No.:** 59447

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

When answering Questions 23-24, refer to the time period beginning on the day you signed your last license renewal with this Board through and including the day you sign this renewal application.
(See Renewal Instructions, page 9.)

YES **NO**

23) Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (see Renewal Instructions, page 9.)

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

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

Signature: Betsy August Date: 3/7/05

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

Massachusetts Physician Renewal Application

Physician Name: BETSY S AUGUST **License No.: 59447**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Betsy August Date: 3 / 07 / 05

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.:** 59447

PART A

1) Current Status: Active **Renewal Due Date:** 04/21/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

400 Highland Ave
Salem, MA 01970

RECEIVED
MAR 19 2007
Board of Registration in Medicine

☑ *Check here to change this address*

Please make corrections (print)

Mailing Address: 55 Highland ave
City/Town: Salem State: Ma
Zip: 01970 Country: USA

2b) HOME ADDRESS

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

Phone:

☐ *Check here to change this address*

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

400 Highland Avenue
Salem, MA 01970

Phone: (978)741-3700

☑ *Check here to change this address*

Business Address: 55 thighland ave
City/Town: Salem State: Ma
Zip: 01970 Country: USA
Business Telephone: ( )

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 978-741-3354

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

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

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Massachusetts General Hospital			☐
North Shore Medical Center - Salem Hospital			☐
			☐
			☐
			☐

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

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

b) outpatient care 60 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

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

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

PART C

Check One: **PHYSICIAN PROFILE**

☒ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

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

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: Betsy August Date: 3/14/07

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

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

Dear Colleague:

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

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

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

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

Sincerely,

Martin C. Crane MD

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs, and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

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

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

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

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

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

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

☒ My current NPI is: 1346231271

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207V00000X	obstetrics and gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: Betsy August Date: 3/14/07

FREQUENTLY ASKED QUESTIONS
REGARDING OFFICE BASED SURGERY- FORM PCA-O

Question #1:
"If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?"

Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form it its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org

Question #2:
"I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?"

The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org

Question #3:
"If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?"

You only have to fill out the form if you perform office-based procedures in Massachusetts.

Question #4:
"I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?"

No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.

Question #5
"I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?"

You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

04/24/08 91
04/13/09 91

PART A

1) Current Status: Active **Renewal Due Date:** 04/21/2009 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

55 Highland Ave
Salem, MA 01970

APR 22 2009 Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: 55 Highland Ave Suite 301
City/Town: Salem State: MA
Zip: 01970 Country:

2b) HOME ADDRESS

Phone:

APR 10 2009 Board of Registration in Medicine

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

55 Highland Avenue
Salem, MA 01970

Phone: (978)741-3700

☐ *Check here to change this address*

Business Address: 55 Highland Ave Ste 301
City/Town: Salem State: MA
Zip: 01970 Country:
Business Telephone: 978) 741.3700

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 978-741-3354

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

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

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Massachusetts General Hospital			☑
North Shore Medical Center - Salem Hospital			☐
			☐
			☐
			☐

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

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

b) outpatient care 60 hrs/wk Change to: ____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/2/09 To 12/31/09

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Betsy S August, M.D. **License No.: 59447**

PART C

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Check One: **PHYSICIAN PROFILE**

- ☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- ☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: Betsy August MD Date: 4/1/09

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