MAY 05 2009
Board of Registration in Medicine

Application #: 241130
Date of Issue: ___/___/___

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

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

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

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

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

☐ M.D. ☒ D.O. ☐ Ph.D ☐ Other degree__________ ☐ Male ☒ Female

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

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

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

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

*Mailing Address:__________ Telephone: __________
Number and Street

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

Home Address: Same as above Telephone: __________
Number and Street

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

Business Address:__________ Telephone: __________
Number and Street

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

E-mail Address:__________ Fax number: __________

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

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

CK.# 1026
05/07/09
WG

PRINT NAME: KAI DACOSTA

Pre-medical School

Facility: Smith College Degree: BA From ~~8/18/03~~ To ~~5/23/08~~
Street: City: Northampton State: MA

Facility: Degree: __/__/__ __/__/__
Street: City: State:

Medical School

Facility: Philadelphia College of Osteopathic Medicine Degree: DO From 8/18/03 To 5/23/08
Street: City: Philadelphia State: PA

Facility: Degree: __/__/__ __/__/__
Street: City: State:

Date of medical school graduation: 6 / 1 / 08
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years. and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

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

Facility: Madigan Army Medical Center Position: intern From 7/1/08 To 6/30/09 (intended)
Street: Fitzsimmons Blvd City: Tacoma State: WA

Facility: Position: __/__/__ __/__/__
Street: City: State:

Facility: Position: __/__/__ __/__/__
Street: City: State:

Facility: Position: __/__/__ __/__/__
Street: City: State:

Facility: Position: __/__/__ __/__/__
Street: City: State:

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I		☐ P	☐ F	
USMLE Step II		☐ P	☐ F	
USMLE Step III		☐ P	☐ F	
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1	~~10/05~~ 10/05	☒ P	☐ F	1
COMLEX Level 2	8/07	☒ P	☐ F	1
COMLEX Level 3	8/08	☒ P	☐ F	1
COMVEX		☒ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

Hospital Affiliations and Employment

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

From To

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

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

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

3. List Board Certification(s): ______ Certification date: __/__/__

   ______ Certification date: __/__/__

4. List your practice specialt(ies) ______

5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: After my military commitment, I will be moving to MA.

7. Name of Facility: ______

   Address: ______ City: ______

8. Anticipated starting date in Massachusetts: 7 / 1 / 11

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full 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] 2 / 17 / 09

Signature of Applicant Month Day Year

(Continued on page 5)

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 full license application to be complete, 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. You must notify the Board once you have received your NPI Number. 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). You must notify the Board once you have received your NPI Number.
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

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

- ☐ My current NPI is: 1 5 7 8 7 1 1 0 1 6
- ☐ I have personally applied for an NPI.
- ☐ 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.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (Taxotomy codes are on following page of this license application and page 12 of Full License Application Instructions). 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:		
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 to any authorized hospital, health plan or health organization.

Signature of Applicant ______________ Date 2/17/09

KAI DACOSTA

EDUCATION

Madigan Army Medical Center – Washington 7/2008 – 6/2009

- Internship in Pediatrics

Philadelphia College of Osteopathic Medicine – Pennsylvania 8/2003 – 5/2008

- Doctor of Osteopathy

KAI DACOSTA

EDUCATION

Madigan Army Medical Center – Washington 2008 - 2009

- Internship in Pediatrics

Philadelphia College of Osteopathic Medicine – Pennsylvania 2003 - 2008

- Doctor of Osteopathy

Wake Technical Community College – North Carolina 1997 - 1999

- Paramedic certification

Smith College – Massachusetts 1989 - 1993

- Bachelor's of Arts in Women's Studies

RESIDENT ACTIVITIES

Lectures

- Contraception in Adolescents
- Pediatric Oncology Board Review
- Scaphoid Fractures: Recognition and Treatment, A Case

Research

- Citi research course completed

Community

- Breastfeeding support group
- Devised Childhood Fever Information brochure for families

MEDICAL STUDENT ACTIVITIES

LEADERSHIP EXPERIENCE

National

Medical Students for Choice (MS4C) – Student Activities Council Osteopathic Representative 2006-2007

- Represented members from 17 medical schools at annual meeting and

American Medical Student Association – National Vote 2004 Swing State Committee, Member 2003 -2004

- Contributed to Kerry/Bush voter information cards made available to all AMSA members
- Organized multiple voter registration drives at PCOM and within the local community at community health centers and grocery stores
- Networked with multiple AMSA chapters to support local voter registration drives

Physicians for a Democratic Majority – Team Leader for Campaign for Patty Wetterling - MN 2004

- Organized, mobilized and supervised team of 11 to participate in Get Out The Vote activities in Senate race in coordination with local campaign

Local

MS4C – Co-Coordinator – PCOM, Pennsylvania 2004 - 2005

- Established club and obtained official club status at PCOM from the Student Government Association
- Organized Emergency Contraceptives/Safe Sex Bar Crawl with 6 area medical school MS4C clubs distributing condoms and EC information to public and medical students
- Organized presentation " What is Choice" for PCOM community

AMSA – Chapter President – PCOM, Pennsylvania 2004 - 2005

- Organized monthly chapter volunteer work with MANNA (Philadelphia HIV/AIDS nutrition provider)
- Organized PCOM community wide clothing drive benefiting local shelter for women and children
- Organized presentation given by Robert Fogel, DO on "The Economics of Health Care"
- Supervised organization of on-going educational series on nutrition/obesity, STD/HIV, smoking at local shelter for at-risk adolescents
- Organized forum for students to learn how to formulate questions and opinions about general election
- Participated in planning and implementation of Philadelphia 5 medical schools AMSA Residency Fair
- Organized pre-election viewing of Fahrenheit 911 and subsequent discussion
- Organizing student participation in health care clinic for local at-risk adolescents staying at local shelter

- Organizing cultural competency training session around medical concerns of religious minorities

Medical Students for Choice (MS4C) – Co-Coordinator – PCOM, Pennsylvania 2004 - 2005

- Established club and obtained official club status at PCOM from the Student Government Association
- Organized Emergency Contraceptives/Safe Sex Bar Crawl with 5 medical school MS4C clubs

MEMBERSHIP/CLUB ACTIVITIES

Student National Medical Association – PCOM, Pennsylvania 2003 - 2005

- Participant in HIP Corp (HIV education/awareness group for at risk minority youth)
- Participated in community health fairs providing information about heart disease, nutrition/obesity/diabetes
- Participated in food preparation and donation to homeless adults

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WORK EXPERIENCE

International Health Volunteer – Nicaragua, Guatemala, El Salvador 2001 - 2003

- Volunteered with women's clinic and emergency response providers

Primary care physician shadow in community health centers – Boston, Philadelphia 2002 - 2004

Paramedic – Philadelphia PA, Boston MA, Jersey City NJ, Durham NC 1998 - 2006

- Trained new employees and preceptees
- Provided emergency triage/treatment and ALS critical care transport in urban and rural pre-hospital settings
- Multiple certifications including CCEMT-P, NREMT-P, ACLS, BLS, PALS, BTLS, PHTLS

Psychiatric Social Worker – Philadelphia 1993 – 1995

- Outreach and case management for chronically mentally ill, homeless adults

24/130

Gomes, Wanda (MED)

From: Kai DaCosta [
Sent: Thursday, August 06, 2009 1:31 AM
To: Wanda (MED)Gomes
Subject: RE: MA License

Good morning,
Could you give me the status of the application.
My new address effective immediately is as follows:

Kai daCosta

Thank you

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, KAI DACOSTA
(type/print your complete name)

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

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

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

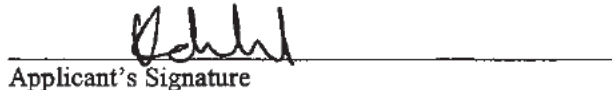
Attention: Licensing

Immunity and Release

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

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

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


Applicant's Signature

2/17/09
Date of Signature

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

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

Full License Application

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

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

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

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

Print or Type Name: DACOSTA (Last name) KAI (First Name) (Middle Initial) Social Security No: ____

Other Name(s) ____
(Please type or print name(s))

Name of Medical School: Philadelphia College of Osteopathic Medicine

Address: 4170 City Ave City: Philadelphia State or Province: PA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

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

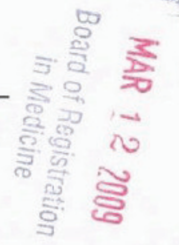
____

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: ____

Undergraduate School Address: ____



(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Da Costa ... Kai

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:

FROM	TO	FROM	TO
08 / 18 / 03	05 / 21 / 2004	05 / 21 / 07	05 / 23 / 08
08 / 16 / 04	05 / 20 / 05	/ /	/ /
05 / 22 / 06	05 / 18 / 07	/ /	/ /

The applicant attended ______ total weeks *or* 42 total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one

☑ was awarded a degree in Doctor of Osteopathic Medicine on (month/day/year) 06 / 01 / 2008

☐ was NOT awarded degree. Please explain reason(s). ______

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

YES **NO**

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: ______

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Katiria E. Lopez

Print Name: Katiria E. Lopez

Title: Ast. Registrar

Date: 03 / 03 / 09 Telephone: (215) 871-6704

This form will not be accepted unless it is stamped with the institutional seal or notarized.

09/23/2009 10:15

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

MEDICARE/TAX FORM

INSTRUCTIONS:

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

I, KAI DACOSTA,
(type or print name)

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

SIGNED: [signature] DATE: 2/17/09

Social Security Number: ______________________

****

Massachusetts General Laws Chapter 112, §2, 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.

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

SIGNED: [signature] DATE: 2/17/09

Revised 9/23/2008

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

PHOTOGRAPH

ed.

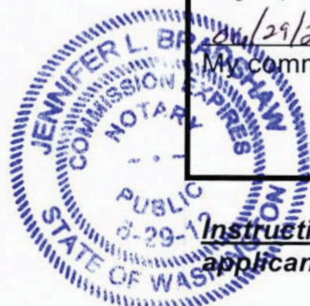
e

[Signature]
Signature of applicant

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

[Signature]
Signature of Notary Jennifer L. Bradshaw
Notary Public in and for the State of Washington

8/29/2012
My commission expires



CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Kai Dacosta ("Kai Dacosta")
(name of applicant)

for 6 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

[Signature] MD
Signature of Certifying Physician

212845 | MA
License Number | State

Nicholas Maypes, MD
Type or print name clearly

Address: 29 Market Square
City: Lynn
State: MA Zip: 01905
Telephone: (781) 596-3500
Date: 3 / 4 / 09

***Instructions to the certifying physician*: Return the completed form to the applicant *in a sealed envelope with your signature across the seal*.**

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

MALPRACTICE HISTORY

DeCosta

<u>Applicant's Instructions:</u> Complete this waiver for release of info current and past liability carrier(s) over the past ten (10) years. If y the past ten (10) years, a copy of this form must be forwarded to y You must account for any gaps in your claims history. If you have photocopy this form. **Please return the <u>completed</u> Malpractice H signature to the Board of Registration in Medicine.**

<u>Waiver for Release of Information</u>
I authorize my professional liability carrier(s) listed below to release Board of Registration in Medicine, my malpractice history <u>and any</u> <u>including the following:</u>

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

<u>Liability Carrier's Instructions</u>: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: tort liability From: 1 JUL 08 To: 30 JUN 09 anticipated
City: ______ State: ______ Policy Number: ______

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

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

Applicant's signature: [signature] 22/May/09
Date

Print Name: KAI DACOSTA

Address: ______ City: ______

State: ______ Zip code: ______

<u>Additional forms available at the Board's website at www.massmedboard.org</u>

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [signature] Date: 6/30/09

Print or Type Name: KAI DACOSTA

Name of Institution: Madigan Army Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Madigan Army Medical Center

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

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

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	Pediatrics	07/01/08	06/30/09	yes	ACGME

JUL 06 2009
Registration Medicine

(Continued on page 2)

DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
TACOMA, WASHINGTON 98431-1100

REPLY TO
ATTENTION OF:

16 July 2009

Department of Pediatrics

SUBJECT: CPT Kai DaCosta

To Whom It May Concern:

CPT Kai DaCosta completed her Pediatric Internship in good standing from 1 July 2008 to 30 June 2009 at Madigan Army Medical Center.

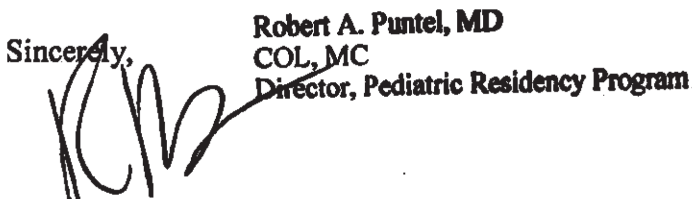
CPT DaCosta completed all rotations successfully and met all competencies for a pediatric intern and for general medical officer training during this time.

It is a requirement of the US Army that physicians obtain a state medical license to practice as a General Medical Officer. CPT DaCosta's assignment as a General Medical Officer in Korea will begin in July 2009 and is necessary for the medical mission of the US Army.

If any further information is needed regardinbg this subject please contact me at 253-968-1852 or 1980. Fax is: 253-968-0384.

Sincerely,

Robert A. Puntel, MD
COL, MC
Director, Pediatric Residency Program



ROBERT A. PUNTEL, M.D., FAAP
COL, MC, USA
Program Director, Pediatric Residency
Madigan Army Medical Center
Tacoma, WA 98431

Printed on Recycled Paper

APPLICANT'S NAME: KAI DACOSTA

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

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

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

COMMENTS; ______________________

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: [signature]

Print Name: Robert A. Puntel, MD ~~COL, MC~~

Academic Title: Director, Pediatric Residency Program

Telephone: (253) 968-1990 Today's Date: 06/30/2009

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

FULL LICENSE APPLICANT

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

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician:______________________________ Date:____/____/____

Print or type name:______________________________

License number:______________ Status of license: ☐ Active ☐ Inactive ☐ Other__________

TO BE COMPLETED BY STATE BOARD

1 Name of medical school of graduation:______________________________

2 Date of graduation: ____/____/____ License number:______________ Date of issue: ____/____/____

3 Basis for licensure:

____
Name(s) of medical licensing examinations(s).

4 Expiration date of license: ____/____/____

5 Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended

6 If revoked or suspended, please explain:______________________________

____

	YES	NO
7 Has the licensee ever been on probation?	☐	☐
8 Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain:______________________________

Other derogatory information:______________________________

Remarks:______________________________

Signed:______________________________

BOARD SEAL

Print Name:______________________________

Title:______________________________

State Board:______________ Date:____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

I have never held a state license in another state. [signature] 22 May 09

SUPPLEMENT FORM

PRINT NAME: KAI DACOSTA DATE: 2 / 17 / 09

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS		YES	NO
1.	Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3.	Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:____________		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5.	Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A.	Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7.	Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: Date: 2/ 17/ 09

02/22/2009 15:19 15

YES **NO**

9-A. Have you ever voluntarily relinquished any medical staff membership?

9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

10. Have you ever been charged with any criminal offense, other than a minor traffic offense?

11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?

13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?

14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

15-B. In the past ten (10) years, 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 has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature: ____________________ **Date:** 2/17/09

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplemental pages for questions #16-A to 19. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

		YES	NO
16-A.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
16-B.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
17-A.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently impaired or limited?		
17-B.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
18.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
19.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 1-19 change while your application is pending, you must immediately notify the Board of the new information.

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

Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting Child Support.

Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for full licensure in Massachusetts.

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

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.

Applicant's Signature: ____________________ **Date:** 2 / 17 / 09