278627

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

FULL LICENSE APPLICATION

Non-refundable Application Fee: A $600.00 check or money order payable to the Commonwealth of Massachusetts must be included with your full license application.

Type of License: ☑ Initial Full License ☐ Administrative License ☐ Volunteer License

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

FCVS: Are you submitting primary source documents (medical education, previous postgraduate training, etc.) for licensure through FCVS? ☐ Yes ☑ No

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

Neill	Sara	Nicole	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

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.)

Degree Type: ☑ M.D. ☐ D.O. ☐ PhD ☐ Other degree _____

☐ Male ☑ Female **Social Security Number:** _____ _____ _____

NPI Number: 1619350295

Date of Birth: ____/____/____ (Month Day Year) **Place of Birth:** _____ (City/State Country if not USA)

***Mailing Address:** _____ (Number and Street) **Telephone** _____

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

Home Address: _____ (Number and Street) **Telephone:** _____

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

Date Received: 2/11/19

Check #: 213

Check Amount: $ 600.00

Initials: RF

PRINT NAME: Sara Neill DATE: 2/7/2019

Business Address: 3535 W 13 Mile Rd, Suite 329 **Telephone:** 248-551-0845
Number and Street

Royal Oak | MI | 48073
City | State/Province/Territory | Zip (or postal) Code

***Email Address:** sara.n.neill42@gmail.com **Fax number:** 248-551-3130

*** The Board will use your Email and/or Mailing Address for all correspondence**

Pre-medical School **From** **To**

Name: University of Michigan Degree: BS Year: 2003 Year: 2007

City: Ann Arbor State: MI Country: USA

Name: Washtenaw community college Degree: N/A Year: 2004 Year: 2004

City: Ann Arbor State: MI Country: USA

Medical School

Name: University of Michigan Medical School Degree: MD

Street: 1301 Catherine St City: Ann Arbor State: MI

Name: Degree:

Street: City: State:

Medical School Graduation Date: 05 / 2015
Month Year

PRINT NAME: Sara Neill DATE: 2/7/2019

Timeline of Activities since Graduation from Medical School:

Please provide a chronological listing by month and year of all activities since graduation from medical school. This would include all postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Failure to complete this section or address any time gaps may result in delay of licensure. Do not write, "See CV" or "See attached"; you must complete this section AND attach your curriculum vitae.

You MUST account for any time gaps of 30 days or more since your graduation from medical school.
(For Example: if you graduated from medical school on May 30, 2015 and started residency on July 1, 2015, you must account for this gap of 30 days on your timeline below.)

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Institution/Place of Employment**	**Address** (City, State/Country)	**Position Held** (Resident, Attending, Research Fellow, etc.)
05/2015	07/2015	None - time off between medical school graduation and start of residency. Time used to move, prepare for residency, etc	Ann Arbor, MI	None
07/2015	06/2019	Beaumont Health System	Royal Oak, MI	Resident
9/2016	9/2017	ACOG (American College of Obstetricians and gynecologists)	Washington, DC	Junior fellow secretary/ treasurer (volunteer)
3/2017	8/2018	University of Michigan	Ann Arbor, MI	Continued research activities - manuscript writing (1 manuscript) for research done in medical school (volunteer)
9/2017	9/2018	ACOG (American College of Obstetricians and Gynecologists)	Washington, DC	Junior fellow vice chair & chair (volunteer)
__/__	__/__			
__/__	__/__			
__/__	__/__			

PRINT NAME: Sara Neill DATE: 2/7/2019

Examination History

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

Please list each medical licensure examination you have taken.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	1	☑ P ☐ F
USMLE Step II CK	1	☑ P ☐ F
USMLE Step II CS	1	☑ P ☐ F
USMLE Step III	1	☑ P ☐ F
NBME Part I		☐ P ☐ F
NBME Part II		☐ P ☐ F
NBME Part III		☐ P ☐ F
FLEX Component 1		☐ P ☐ F
FLEX Component 2		☐ P ☐ F
FLEX Pre-1985		☐ P ☐ F
COMLEX Level 1		☐ P ☐ F
COMLEX Level 2		☐ P ☐ F
COMLEX Level 3		☐ P ☐ F
MCCQE – Part I		☐ P ☐ F
MCCQE – Part II		☐ P ☐ F
State Board Exam	State of Examination:	☐ P ☐ F

PRINT NAME: Sara Neill DATE: 2/7/2019

Opioid and Pain Management Training: (You must check one. See Instructions.)

- ☑ I completed three (3) credits of Board-approved CPD/CME credit in effective pain management. (i.e., www.opioidprescribing.com)
- ☐ I do not prescribe controlled substances (Schedules II – VI).

Child Abuse or Neglect Recognition and Reporting Training: (You must check one. See Instructions.)

- ☑ I received training in child abuse and neglect assessment in medical school or postgraduate training.
- ☐ I completed a hospital sponsored training program in recognizing the signs of child abuse and neglect.
- ☐ I completed a CPD/CME program in identifying and reporting child abuse and neglect.
- ☐ I completed an online training program (i.e. The Middlesex Children's Advocacy Center's program "51A Online Mandated Reporter Training: Recognizing and Reporting Child Abuse, Neglect and Exploitation" www.middlesexcac.org/51A-reporter-training).
- ☐ I completed a specialized certification (i.e., Child Abuse Pediatrics)

Domestic and Sexual Violence Education and Training: (You must complete. See Instructions.)

- ☒ I completed the Massachusetts Department of Public Health online training in Domestic and Sexual Violence for licensed healthcare professionals. https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

MassHealth Enrollment Requirement: (You must check one. See Instructions.)

- ☐ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider. (Nonbilling application: https://www.mass.gov/files/documents/2018/10/09/pe-nbp.pdf)
- ☒ I am enrolled or have applied to enroll in MassHealth as a billing provider. (Billing provider application must be requested through MassHealth at 1-800-841-2900)

Curriculum Vitae:

- ☒ I have enclosed a current curriculum vitae (CV) with my application.

Out-of-State Licensure: List the state abbreviations where you currently or have ever had a full license:

None

Board Certification: (You must complete.)

a) Are you certified by the American Board of Medical Specialties (ABMS)? ☐ Yes ☑ No
If yes, list Board Certification(s): _____

b) Are you certified by the American Board of Osteopathic Medicine (AOA)? ☐ Yes ☑ No
If yes, list Board Certification(s): _____

PRINT NAME: Sara Neill DATE: 2/7/2019

Practice Specialty: List the medical specialt(ies) that you practice. The medical specialties listed will be included on your Physician Profile to help consumers locate physicians in specific specialties. (If you are completing postgraduate training, list that specialty here):

Obstetrics and Gynecology

Please answer the following questions.

1. Reason for requesting a Massachusetts medical license:

   To pursue fellowship in Obstetrics & gynecology at Harvard Medical School/Brigham & Women's

2. Name of anticipated practice location/facility: Brigham & Women's Hospital, obstetrics & gynecology

   Address: 75 Francis St City: Boston, MA 02115

3. Anticipated starting date in Massachusetts: 07 / 01 / 2019

Declaration and Signature

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 and evidence or other credentials submitted herewith are true, correct and complete. I understand that any falsification or misrepresentation of any item or response on this application or any attachment hereto may be a sufficient basis for denying or revoking a license.

Signature of Applicant

02 / 07 / 2019
Month Day Year

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Sara Neill
(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

2/7/2019
Date of Signature

Neill, Sara, N
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

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

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

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

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

SECTION 3. SIGNATURE

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

NAME: _____ DATE: 2/7/19

Sara N Neill, MD

EDUCATION

Beaumont Health System, Royal Oak, MI
Residency, Department of Obstetrics and Gynecology
Expected completion: June 2019

University of Michigan Medical School, Ann Arbor, MI
Medical Doctor, 2015

University of Michigan, College of Literature, Science, and the Arts, Ann Arbor, MI
Bachelor of Science, with honors, 2007
Major Concentration: Microbiology
Minor Concentration: Gender and Health

RESEARCH EXPERIENCE

Rates of Urine Drug Screening in an Obstetrical Triage Unit
Co-Investigator. PI: Lori Mausi, MD
Beaumont Health System, Royal Oak, MI. July 2018 – Current
-Designed a retrospective study to assess rates of urine drug screening in an obstetrical triage unit, focusing on disparities in screening based on race, publicly versus privately insured patients, and known risk factors for substance abuse in pregnancy
-Currently in data collection phase

Authorship In Abortion Research
Co-Investigator. PI: Lisa Harris, MD, PhD
University of Michigan, Ann Arbor, MI. 2012- Current.

-A quantitative study examining the rates at which abortion research is authored by clinician-researchers who provide abortions compared to other surgical procedures and an examination of the critiques of abortion research.
-Currently editing final manuscript for submission.

Targeted Infection Prevention Program: Preventing nosocomial infections in skilled nursing facilities
Research Assistant, Medical Students for Aging Research (MSTAR) Fellow.
PI: Lona Mody, MD, MPH
University of Michigan Health System and Department of Veterans Affairs, Ann Arbor, MI. 2012-2013.

- NIH-funded randomized trial aiming to reduce nosocomial infection in skilled nursing facilities.
-Responsible for obtaining patient cultures and chart review.
-Assisted in the implementation of staff education programs on infection prevention.
-Designed an additional study examining differences in infection rates and other health outcomes between patients with urethral and suprapubic urinary catheters - work published in the Journal of Hospital Infection

Abortion & Stigma Research Group ("The Legitimacy Paradox")
Research Assistant, Summer Biomedical Research Program.
PI: Lisa Harris, MD, PhD
University of Michigan Medical School, Ann Arbor, MI. 2011.
-Responsible for literature review and support regarding the role of stigma in abortion provision.

PUBLICATIONS AND PRESENTATIONS

Peer-Reviewed:

Gibson, K. **Neill, S.** Tuma, E. Meddings, J. Mody, L. Indwelling Urethral vs. Suprapubic Catheters in Nursing Home Residents: Determining the Safest Option for Long-Term Use. *Journal of Hospital Infection*. (2018)

Neill SN. Bauer S. A rare case of heterotopic cervical pregnancy. Poster presentation, Michigan Section ACOG; 2018.

Hage N. **Neill SN**. Zeynep-Savasan A. A case report of molar twin gestation. Poster presentation, Beaumont Health System Research Forum; 2018.

Martin L, **Neill SN**, Debbink M, Eagen M, Youatt E, Harris LH. Expertise or conflict of interest? Comparing abortion providers to other authors who perform the procedures they investigate. Poster Presentation, National Abortion Federation; 2013.

In preparation:

Neill, SN. Haque, F. Wallach, P. Skochelak, S. Stagg Elliot, V. Hammoud, M. Sexual Harassment of Learners in the Clinical Environment: Current Climate and Best Practices for Prevention and Response.

Neill, SN. Martin, L. Mosley, E. Harris, LH. Authorship in Abortion Research: Expertise or Conflict of Interest?

Other Publications:

Panelist, Sexual Harassment in the clinical learning environment. Accelerating Change in the Medical Education Community. American Medical Association. Online panel, available at: https://ace.communities.ama-assn.org/discussions/583. January 2018.

Arnold, KC, **Neill SN**, Hammer KC, Cheschier NC. (2017). Connect the Dots – August 2017: PTSD and Antepartum Complications: A Novel Risk factor for Gestational Diabetes and Pre-eclampsia. Obstetrics & Gynecology, 130(2), 461-462.

Donaghy, AC, **Neill, SN** Clay, M., & Skye, EP. (2012). Artists' Statement: Two Worlds Apart. *Academic Medicine*, 87(12), 1741.

WORK EXPERIENCE & SERVICE

Graduate Student Instructor, Department of Women's Studies, University of Michigan, Ann Arbor, MI. 2011-2012.

Professor: Lisa Kane-Low CNM, PhD, Joanne Motino-Bailey CNM.

-Instructor for "Perspectives in Women's Health", an introductory level course for undergraduate students focusing on the intersection between gender, race, ability, sexuality, and health.

HIV Educator and Testing Coordinator, Georgetown University Department of Infectious Disease. AmeriCorps, Washington AIDS Partnership. Washington, DC. 2009-2010.

-Assisted with grant writing and programming. Created and facilitated support groups for HIV serodiscordant couples and was responsible for medical case management. Partnered with the department of Internal Medicine to initiate an HIV "opt-out" testing program within the division of Internal Medicine.

Outreach Specialist, Helping Individual Prostitutes Survive (HIPS). AmeriCorps, Washington AIDS Partnership. Washington, DC. 2008-2010.

-Conducted harm-reduction focused outreach and needle exchange to street-based sex workers and drug users; supervised and facilitated volunteers during outreach; responded to crisis calls. Implemented CDC evidence based intervention programs for male sex workers and transgender women of color.

EDITORIAL & REVIEW WORK

American College of Obstetrician Gynecologists (ACOG), District V

Junior Fellow reviewer of scientific abstracts for ACOG District V Annual Clinical Meeting, 2018

Eworld Editing

Editor and reviewer, 2011-2015

Provided review and editing, primarily for manuscript structure and grammatical content, for > 100 manuscripts from authors w/ english as a second language who

were submitting scientific writing to english language journals. Subjects covered included a wide range, from materials engineering to basic science and clinical research.

LEADERSHIP

American College of Obstetrician Gynecologists (ACOG)
District V Junior Fellow Vice Chair, September 2017 – current
Member of Junior Fellow Advisory Council
Chair of Junior Fellow Legislative Advocacy workgroup
ACOG Robert C. Cefalo National Leadership Institute graduate, April 2018

American College of Obstetrician Gynecologists (ACOG)
District V Junior Fellow Secretary-Treasurer, 2016-2017

Phi Rho Sigma Medical Society, University of Michigan Chapter
Social Chair, 2011-2012

Washington AIDS Partnership AmeriCorps Team
Team Coordinator, 2009-2010

PROFESSIONAL MEMBERSHIPS

American College of Obstetricians and Gynecologists, 2015 – current
American Medical Association, 2010 - current
Medical Students for Choice, 2010-2015

Sealed Envelope Initials AS

RECEIVED
FEB 8 2019
Board of Registration in Medicine

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

Applicant's Signature: _____ Date of Birth: _____

Name (Please type or print): O'Neill (Last Name) Sara (First Name) N (Middle Initial)

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

Name of Medical School: University of Michigan Medical School

Address: 1301 Catherine St City: Ann Arbor State or Province: MI

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Michigan

Undergraduate School Address: Ann Arbor, MI

RECEIVED

FEB 8 2019

Board of Registration in Medicine

Enrollment and Participation:

Our records indicate that Neill (Last name) Sara (First name) N (Middle Initial)
(Print the applicant's name):

attended our medical school for a total of 152 weeks (must be included) of continuous medical education on the following dates from 08/02/2010 (month/day/year) to 05/01/2015 (month/day/year)

This applicant:

Check one: [X] **was awarded** the degree of Doctor of Medicine on 05/15/2015 (month/day/year)

☐ **will be awarded** the degree of _____ on ____/____/____ (month/day/year)
(Form B must also be completed and returned directly to the Board.)

☐ **was not awarded** a degree because: _____

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

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?		
2. Was the applicant ever placed on probation or remediation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Cynthia Murphy

Print Name: Cynthia Murphy

Title: UMMS Registrar

Date: 11/1/2018 Telephone: (734) 936-1476

E-mail address: RegAssist@umich.edu

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

Seal Verified
DATE: 2-12-19
INITIALS: AD

Sealed
Envelope
Initials AD

Seal Verified
DATE: 2-12-19
INITIALS: AD

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

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blic.

Signature of applicant

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

Michelle L Ridky
Signature of Notary

9-17-2025
My commission expires

MICHELLE L RIDKY
NOTARY PUBLIC - STATE OF MICHIGAN
COUNTY OF MACOMB
My Commission Expires September 17, 2025
Acting in the County of

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Sara Neill, M.D.
(name of applicant)

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

Patricia M. Franz MD
Signature of Certifying Physician

4301061796 License Number
MI State

Patricia Franz, M.D.
Type or print name clearly

Address: Beaumont Hospital, Royal Oak
3601 W. 13 Mile Road
City: Royal Oak State: MI Zip: 48073
Telephone:
Date: 1/30/2019

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

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/22/19

Print or Type Name: Sara Neill

Name and Address of Institution: Beaumont Health System
3601 W 13 Mile Rd
Royal Oak MI 48073

TO BE COMPLETED BY PROGRAM DIRECTOR

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

Name of Institution: Beaumont Hospital - Royal Oak

Name of Institution, if different when applicant attended: _____

Verification for: Sara N. Neill, MD
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Residency	1	OB/GYN	7/1/15	6/30/16	Yes	ACGME
Residency	2	OB/GYN	7/1/16	6/30/17	Yes	ACGME
Residency	3	OB/GYN	7/1/17	6/30/18	Yes	ACGME
Residency	4	OB/GYN	7/1/18	6/13/19	In Progress	ACGME
			/ /	/ /		

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

APPLICANT'S NAME: Sara Neill

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

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

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Patricia Franz MD

Print Name: Patricia Franz MD

Academic Title: Residency Program Director

Telephone: (248) 551-0845 Today's Date: 1/17/2019

E-mail address: patricia.franz@beaumont.edu

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

Seal Verified
DATE: 2-12-19
INITIALS: AD

Michelle L. Ridky

MICHELLE L RIDKY
NOTARY PUBLIC - STATE OF MICHIGAN
COUNTY OF MACOMB
My Commission Expires September 17, 2025
Acting in the County of Oakland

PRINT NAME: Sara Neill DATE: 2/7/2019

FULL LICENSE APPLICATION SUPPLEMENT

SUPPORTING DOCUMENTATION: If you answer "yes" to any of these questions, you must provide a detailed explanation and arrange for the appropriate agency or institution to submit copies of all official documentation related to the underlying occurrence or action. Documents should be sent either directly to the Board from the appropriate agency/institution or to you in a sealed envelope. If the documents are sent to you, the sealed envelopes must be included with your full license application or sent directly to the Board unopened.

IMPORTANT NOTE:
It is your responsibility to report to the Board if your responses to Questions 1-31 change while your application is pending. You must immediately notify the Board of the new information.
Please review each question carefully to ensure your answers are accurate prior to submitting your application. You are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Board's assessment of your present moral character and fitness to practice, but a dishonest "no" answer may be evidence of a lack of candor and honesty, which may be definitive on the character and fitness to practice issue. **Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks.**

POST-SECONDARY EDUCATION – (COLLEGE/GRADUATE /MEDICAL SCHOOL)	YES	NO
1. While enrolled in college, medical school or graduate school were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2. Have you ever been terminated from a medical school?		
3. Have you ever withdrawn or transferred from a medical school?		
4. Have you ever been granted a leave of absence by a medical school? (This includes a leave for research, public service, participated in a joint degree program such as an M.D./Ph.D. program, medical leave or for any other "personal reasons".)		
5. Have you ever been placed on probation or remediation by a medical school or graduate school?		
6. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		

PRINT NAME: Sara Neill DATE: 2/7/2019

POSTGRADUATE TRAINING **YES** **NO**

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

8. Have you ever been suspended, terminated or dismissed from any postgraduate training program?

9. Have you ever had to repeat a year of postgraduate training?

10. Have you ever withdrawn or transferred from a postgraduate training program?

11. Have you ever been granted a leave of absence from a postgraduate training program?
(This includes a leave for research, public service, medical leave or for any other "personal reasons".)

12. Have you ever been placed on probation or remediation by a postgraduate training program?

13. Were any limitations or special requirements imposed on you because of questions of competency or disciplinary problems?

14. Did you ever receive partial or no credit for a postgraduate training program?

15. Have you ever had a postgraduate training program contract not be renewed?

PRINT NAME: Sara Neill DATE: 2/7/2019

ACTIONS BY ANY HEALTH CARE FACILITY, EMPLOYMENT, PROFESSIONAL ORGANIZATION, STATE BOARD OR ANY OTHER GOVERNMENTAL AGENCY	YES	NO
16. Have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
17. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
18. Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
19. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
20. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
21. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		
22. Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
23. Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
24. Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
25. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
26. Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		

PRINT NAME: Sara Neill DATE: 2/7/2019

CRIMINAL HISTORY **YES** **NO**

27. Have you ever been charged with any criminal offense?
(You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application.)

Expunged/Sealed Offenses: While expunged/sealed offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

MEDICAL MALPRACTICE HISTORY **YES** **NO**

28. Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim?
(You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.)

PRINT NAME: Sara Neill DATE: 2.7.2019

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 29 - 31. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician, or within the past two years.

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

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

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

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

PRINT NAME: Sara Neill DATE: 2/7/2019

CERTIFICATIONS

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

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

Applicant's Signature: _____ Date: 2/7/2019

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sara N Neill, M.D. **License No.:** 278627

Current Status: Active **License Expiration Date:** 4/25/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
75 Francis Street
Department of Obstetrics & Gynecology
Boston
Michigan - 02115
United States of America
(617) 732-7601

3) **Email Address:**

4) **Fax Number:** (617) 730-2833

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
None Reported			

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

WorkSite	Location
Brigham & Women's Hospital	

Physician Name: Sara N Neill, M.D. **License No.:** 278627

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2020	12/31/2020	Claims made with tail coverage

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

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

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

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?

Physician Name: Sara N Neill, M.D. **License No.:** 278627

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 engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?

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: Sara N Neill, M.D. **License No.:** 278627

☒ **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.**