Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200
www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781)876-8383

November 30, 2020

VIA EMAIL ONLY

[redacted]

Dear [redacted]:

The Commonwealth of Massachusetts, Board of Registration in Medicine (the "Board"), hereby responds to the above-referenced public records request, received on November 22, 2020 (the "request"), wherein you requested "Would you kindly send all the complaints, disciplined, closed claim reports, lawsuits, license applications and reapplications, references, statutory reports, resumes, and everything else in your file pertaining to Joshua H. St. Louis, M.D. License Number 273183."

Enclosed are 35 pages of records responsive to your request, which consists of Dr. Applewhite's initial and renewal applications, and one waiver to permit the release of his information. Please be advised that certain portions of the applications have been redacted and/or some records withheld from production due to an exemption pursuant to G.L. c. 4, § 7(26), as specified below:

- Personal information, including but not limited to social security numbers, drug provider identification numbers, home addresses, personal telephone numbers, personal email addresses, and dates of birth (*see* G.L. c. 4, § 7(26)(a) and (c); *see also* G.L. c. 66A, § 2; *see also* G.L. c. 93H; *see also* Board Policy 98-02); and

- Physician evaluations and/or evaluative files, including but not limited to character evaluations, academic evaluations, and academic transcripts (*see* G.L. c. 4, § 7(26)(c)).

Dr. St. ouis has no closed complaints or disciplinary history with the Board

The Board reserves the right to retrieve any exempted, privileged, or otherwise protected materials inadvertently included in this production. Any such production is not, and shall not be considered or deemed, a waiver of any applicable privileges or protections from disclosure.

The Board now considers this request closed.

If you believe the agency has violated G.L. c. 66, § 10, pursuant to G.L. c. 66, § 10A, and 950 CMR 32.08(1), you may submit an appeal to the Supervisor of Public Records in the Office of the Secretary of the Commonwealth or seek judicial review by commencing a civil action in Suffolk Superior Court.

Sincerely,

Tara Douglas
Assistant General Counsel

Enclosure

90-Day Form

Dear Doctor,

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

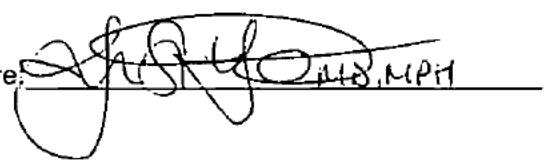
Thank you.

Please select one of the boxes below:

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

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

My birthdate is _____ (Month) _____ (Day) _____ (Year)

Signature:  Today's Date: 07 (Month) / 03 (Day) / 2017 (Year)

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

273183

RECEIVED
JUL 27 2017
Board of Registration in Medicine

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

FULL LICENSE APPLICATION

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

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

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

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

ST. LOUIS | JOSHUA | HENRY | _____
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ PhD ☐ Other degree _____ ☒ Male ☐ Female

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

ST LOUIS | JOSHUA | HENRY | _____
Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

Social Security Number: 018 / 68 / 2000 Date of Birth: _____
Month Day Year

NPI (National Provider Identifier) Number: 1437562121

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

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: 34 HAVERHILL ST. Telephone: 978-686-0090
Number and Street

LAWRENCE | MA | 01840
City | State/Province/Territory | Zip (or postal) Code

E-mail Addres | Fax number: 978-687-1947

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

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

Date Received: 7/27/17

Check #: 263

Check Amount: $ 600.00

Initials: RF

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

Name: HARVARD COLLEGE Degree: A.B. Year: 2005 Year: 2009
Street: 86 BRATTLE ST. City: CAMBRIDGE State: MA

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

Medical School

Name: TUFTS UNIVERSITY SCHOOL OF MEDICINE Degree: MD, MPH
Street: 145 HARRISON AVE. City: BOSTON State: MA

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

Medical School Graduation Date: 05 / 2014
Month Year

Postgraduate Education:

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

From **To**

Facility: Lawrence Family Medicine Residency PGY Year: 1-4 06/2014 Present
Specialty: Family Medicine City: Lawrence State: MA

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Examination History

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

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

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

Hospital Affiliations and Employment

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

From To

Facility:______________________ 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): None

4. List your practice specialt(ies): Family Medicine

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

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

7. Reason for requesting a Massachusetts medical license: Intend to begin practicing.

8. Name of Facility: Greater Lawrence Family Health Center
   Address: 34 Haverhill St., City: Lawrence,

9. Anticipated starting date in Massachusetts: 10 / 01 / 2017

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

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

[signature] MD, MPH
Signature of Applicant

07 / 03 / 2017
Month Day Year

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Joshua H. St. Louis
(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 — Date of Signature: 7/3/17

ST. LOUIS, JOSHUA, H.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

____ Participation in a Meaningful Use program as an eligible professional;
__X__ 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: [signature] MD, MPH DATE: 07/13/2017

Joshua St. Louis, M.D., M.P.H.

EDUCATION

Harvard University, Cambridge, MA 09/05-05/09
Bachelor of Arts *cum laude* in Organismic and Evolutionary Biology
Language Citation in Spanish

Tufts University School of Medicine, Boston, MA 08/10-05/14
Doctor of Medicine
Master of Public Health

POSTDOCTORAL TRAINING

Lawrence Family Medicine Residency, Lawrence, MA 06/14-06/18
Area of Concentration: HIV Primary Care

ACADEMIC, CLINICAL, AND LEADERSHIP APPOINTMENTS

Chief Resident, Lawrence Family Medicine Residency	2016-2018
Visiting Scholar, University of Zambia School of Medicine	February 2016
Clinical Associate in Family Medicine, Tufts University School of Medicine	2014-Present

HONORS, GRANTS, AND AWARDS

LGBT Health Disparities Grant, Massachusetts Medical Society	2017
Medical Students for Choice Training to Competence Externship	2017
Ruth Fox Scholar, American Society of Addiction Medicine	2017
The Training Fund Scholar, Reproductive Health Access Project	2017
Family Medicine Leads Scholar, American Academy of Family Physicians	2016-17
AFMRD Family Medicine Resident Award for Advocacy	2016
Benjamin H. Josephson Global Health Scholar	2016
Massachusetts Medical Society Scholar	2014
Dr. Toby Wesselhoeft Family Medicine Award, Tufts University School of Medicine	2014
Honos Civicus Society, Tufts University School of Medicine	2014
HIV Psychiatry Scholar, American Psychiatric Association	2013
Student Innovation Fellow, Center for Primary Care, Harvard Medical School	2011-13
Global Health Scholar, Tufts University School of Medicine	2010

LICENSURE AND CERTIFICATION

BLS for Healthcare Providers	5/16-5/18
Advanced Cardiovascular Life Support	6/16-6/18
Neonatal Resuscitation Program	7/14-7/16
Pediatric Advanced Life Support	4/15-4/17
Advanced Life Support in Obstetrics	1/15-1/20

OTHER PROFESSIONAL ACTIVITIES

Lawrence General Hospital Healthcare Leadership Course	9/16-6/18
Advanced Life Support in Obstetrics Instructor	10/15-10/20
Institute for Healthcare Improvement Basic Certificate in Quality and Safety	10/16

REGIONAL & NATIONAL COMMITTEES:

LGBT Health Workforce Conference
Trainee Committee (Resident Member) 2015

Massachusetts Medical Society

House of Delegates (Essex County North District Delegate)	2014-Present
Committee on LGBTQ Matters (Resident Member)	2015-2016

HOSPITAL, CLINIC OR MEDICAL SCHOOL COMMITTEES:

Greater Lawrence Family Health Center

Advocacy Champions Committee (Member)	2016-Present
LGBT Education Working Group (Founder, Member)	2014-Present
Diversity Working Group (Founder, Member)	2014-Present

Lawrence General Hospital

Diversity Committee (Member, LGBTQ Representative)	2015-Present
Antibiotic Stewardship Committee (Resident Member)	2015-Present
Pharmacy and Technology Committee (Resident Member)	2014-Present
Neonatal Abstinence Syndrome Committee (Resident Member)	2014-2015

TEACHING RESPONSIBILITIES

Tufts University School of Medicine Courses

Competency-Based Apprenticeship in Primary Care *Physical Diagnosis Workshop- 2nd year students*	Fall 2015
Medical Interviewing and the Doctor-Patient Relationship *Section Leader- 1st year students*	Fall 2013

PROFESSIONAL SOCIETIES

American Society of Addiction Medicine	2016-Present
Gay and Lesbian Medical Association	2014-Present
HIV Medicine Association	2014-Present
Infectious Disease Society of America	2014-Present
Society of Teachers of Family Medicine	2014-Present
American Academy of Family Physicians	2013-Present
Massachusetts Academy of Family Physicians	2013-Present
Family Medicine Education Consortium	2012-Present
Massachusetts Medical Society	2012-Present

MENTORING EXPERIENCE

Harvard Alumni First Generation Mentor Program

Board Member, Mentorship Committee	2015-2016
First Year College Student Mentor	2012-Present

EDUCATIONAL TRAVEL

American Society of Addiction Medicine National Conference	2017
ASAM Fundamentals of Addiction Medicine Workshop	2017
American Academy of Family Physicians National Conference	2016, 2013
American Academy of Family Physicians FMX Conference	2016
Chief Resident Leadership Development Program	2016
Family Medicine Congressional Conference	2016, 2015
Family Medicine Leads Scholars Leadership Academy	2016
Gay and Lesbian Medical Association Annual Conference	2016
Massachusetts Academy of Family Physicians Spring Refresher	2016, 2014, 2013
Society of Teachers of Family Medicine National Conference	2016
Advancing Excellence in Transgender Health, Fenway Institute	2015
Family Medicine Educational Consortium Annual Conference	2015, 2012
Massachusetts Public Health Association Annual Conference	2014
Primary Care Innovations Conference, Harvard Center for Primary Care	2014, 2013
Transgender Medicine Conference, Brown University School of Medicine	2014

BIBLIOGRAPHY

Poster Presentations at Professional Meetings

1. **St. Louis, J.**, Cheng, J., McAnaney, C., and DellaFera, C. "Creation of a Resident-Led LGBT Primary Care Curriculum in a Four Year Family Medicine Residency." *Gay and Lesbian Medical Association Annual Conference on LGBT Health,* St. Louis, MO, September 2016.
2. LeFevre, W., **St. Louis, J.,** and Johnston, J. "Incorporating Group Well-Child Visits in a Residency Setting: A Pilot Group." *Massachusetts Academy of Family Physicians Spring Refresher Conference*, Boston, MA, March 2016. *Family-Centered Maternity Care Conference*, Madison, WI, August 2016.
3. DeMasi, M., **St. Louis, J.,** et al. "Creating a Diabetes Group Visit for Brazilian Immigrants." *Institute for Healthcare Improvement National Forum on Quality Improvement in Health Care*, Orlando FL, December 2013. *American Academy of Family Physicians National Conference*, Kansas City MO, August 2013. *Family Medicine Education Consortium Meeting*, Cleveland OH, September 2012.

Thesis / Academic Presentations

1. *"O Meu Bebê Lindo:* A Novel Group Well-Child Visit for Brazilian Mothers and Babies." Applied Learning Experience, Accepted in Partial Fulfillment of Degree Requirements of Master's of Public Health. Adviser: Kirsten Meisinger, M.D., Cambridge Health Alliance, Somerville, MA. Tufts University School of Medicine, 2014.
2. "Investigation of Socio-Demographic Risk Factors for tuberculosis / HTLV-1 Co-Infection." Public Health Field Experience, Accepted in Partial Fulfillment of Degree Requirements of Master's of Public Health. Adviser: Fernanda Grassi, Ph.D., CPqGM/Fiocruz, Salvador, Bahia, Brazil. Tufts University School of Medicine, 2012.

Invited Lectures

Local

1. **St. Louis, J.,** and Barlow, M. "24 year old prenatal patient with pyelonephritis and septic shock." *Morbidity and Mortality Conference* 2015. Sponsor: Lawrence General Hospital, Lawrence, MA.
2. **St. Louis, J.,** and DellaFera, C. "Pediatric Sepsis: One month old male with respiratory arrest." *Morbidity and Mortality Conference* 2014. Sponsor: Lawrence General Hospital, Lawrence, MA.
3. **St. Louis, J.** "Medicine, Public Health, and the Importance of Self-Motivation." *Woodsville High School Alumni Talks* 2014. Sponsor: Woodsville High School, Woodsville, NH.
4. Altman, W., and **St. Louis, J.** "Making a Greater Impact on Patient Lifestyle and Disease Prevention: Motivational Interviewing, Group Medical Visits, and the Patient-Centered Medical Home." *Competency-Based Apprenticeship in Primary Care* 2014. Sponsor: Tufts University School of Medicine, Boston, MA.

Regional, National, & International

1. **St. Louis, J.,** and DellaFera, C. "Transgender Care for Family Physicians." *Massachusetts Academy of Family Physicians Spring Refresher Conference*, Boston, MA, March 2017 (Accepted).
2. McAnaney, C., **St. Louis, J.,** and Cheng, J. "Cultural Bias in Taking a Sexual History." *Gay and Lesbian Medical Association Annual Conference on LGBT Health,* St. Louis, MO, September 2016.
3. LeFevre, W., **St. Louis, J.,** and Johnston, J. "Incorporating Group Well-Child Visits in a Residency Setting: A Pilot Group." *Society of Teachers of Family Medicine National Conference*, Minneapolis MN, April 2016.
4. **St. Louis, J.** "LGBT Primary Care: A Primer." *Massachusetts Academy of Family Physicians Spring Refresher Conference*, Boston, MA, March 2016.
5. Gravel, J., Douglass, A., and **St. Louis, J.** "Family Medicine Residency 4 Year Length of Training: What Do Residents Think?" *Family Medicine Education Consortium.* Danvers MA, October 2015.
6. **St. Louis, J.** "The Power of Suggestion: Making Primary Care a More Attractive Option for Medical Students." *Primary Care Center Innovations Conference.* Harvard Medical School, Boston MA, October 2013.

Regional, National, & International (Continued)

7. DeMasi, M., **St. Louis, J.** "Working with Students on your Clinical Innovation Project." *Academic Innovations Collaborative Conference.* Harvard Center for Primary Care, Boston MA, January 2013.

Non-print Publications

Practice Quality Improvement Materials

1. Group Well-Child Visit Curriculum, Material, Protocols, and Templates (Spanish); 2015
2. Group Well-Child Visit Curriculum, Material, Protocols, and Templates (Portuguese); 2014

Educational Curricula

1. Lawrence Family Medicine Residency Self-Teaching Curriculum in Cross-Sex Hormone Therapy; 2016
2. Lawrence Family Medicine Residency Curriculum in LGBTQ Health; 2015

Media / Lay Press Interviews

1. Aaronson, B. "Generation to Generation." *Harvard College Alumni Magazine.* March 16, 2015. **http://alumni.harvard.edu/stories/generation-to-generation**

Blog Posts / Editorials

1. **St. Louis, J.** and Desmond, D. "Primary care physicians should advocate for fewer restrictions on women's choices." *KevinMD.* July 22, 2016. **http://www.kevinmd.com/blog/2016/07/primary-care-physicians-advocate-fewer-restrictions-womens-choices.html**.
2. **St. Louis, J.** "Resident Offers Practical Advice to Upcoming Residency Applicants." *Primary Care Progress.* January 29, 2015. **http://www.primarycareprogress.org/blogs/16/460**.
3. **St. Louis, J.** "M.P.H. Prepares Med Students For Careers in Primary Care." *Primary Care Progress.* June 20, 2013. **http://www.primarycareprogress.org/blogs/16/267**. Re-blogged by *KevinMD.com* as "The benefit of a public health degree in medical education" on July 29, 2013.
4. **St. Louis, J.** "Clinical Innovation in the Aisles of the Supermarket." *Primary Care Progress.* February 7, 2013. **http://www.primarycareprogress.org/blogs/16/214**. Re-blogged by *KevinMD.com* as "Can group visits be an ideal way to practice primary care?" on March 16, 2013.

INTERESTS

Social justice, advocacy, mentorship, teaching, public health, primary care innovation, LGBT health, transgender medicine, family-centered obstetrics, HIV primary care, addiction medicine, reproductive health and advocacy, group medical visits, inpatient medicine

LANGUAGES

Québécois French- fluent; **Spanish**- fluent; **Portuguese**- fluent; **Haitian Creole**- beginner

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

Print or Type Name: St. Louis (Last name) Joshua (First Name) H (Middle Initial) U.S. Social Security No:

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

Name of Medical School: Tufts University School of Medicine

Address: 136 Harrison Ave City: Boston State or Province: MA 02111

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Harvard College

Undergraduate School Address: Cambridge, MA

(Continued on page 2)

Enrollment and Participation: Our records indicate that St. Louis (Last name) Joshua (First name) H. (Middle initial)
(print the applicant's name):

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	8/17/10	5/24/11	5/13/13	4/25/14
	8/15/11	4/27/12	/ /	/ /
	5/7/12	4/19/13	/ /	/ /

The applicant attended 146 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

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

☒ will be awarded on 5/18/14 **(Form B must also be completed and returned directly to the Board)**

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

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

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Carol A. Duffey

Print Name: Carol A. Duffey

Title: Assistant Dean for Student Enrollment/Registrar

Date: 4/1/14 Telephone: (617) 636-6568

E-mail address: carol.duffey@tufts.edu

Seal Verified DATE: 5/22/14 INITIALS: CAD

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

Grantee Lawrence

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that Joshua St. Louis
(Student's Name)

has completed the requirements for the ☒ M.D. degree ☐ D.O. degree

from Tufts University School of Medicine
(Name of Medical School)

and will receive the degree on 5 /18 / 2014.

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

Printed Name: Carol A. Duffey

Title: Assistant Dean for Student Enrollment/Registrar

Date: 5/19/14

Please return the completed Form B to the Limited License Coordinator, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - Telephone: (781) 876-8210 Fax: (781) 876-8383. Thank you

Sealed Envelope

Initials: GH

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

PHOTOGRAPH

A
p
p
Y
p

Signature of applicant

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

Signature of Notary

9/16/22
expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Joshua St. Louis
(name of applicant)

for 3 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of Certifying Physician

244387 — License Number

MA — State

Wendy Barr
Type or print name clearly

Address: 34 Haverhill St.

City: Lawrence State: MA Zip: 01841

Telephone: (978) 689-6630

Date: 7/14/17

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

Seal Verified
Date: 7/28/17
Initials: GH

Sealed Envelope

Initials:

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: 7/21/17

Print or Type Name: Joshua St. Louis

Name and Address of Institution: Greater Lawrence Family Health Center
34 Haverhill Street
Lawrence, MA 01841

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: Greater Lawrence Family Health Center

Name of Institution, if different when applicant attended: _____

Verification for: Joshua St. Louis
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Internship	1	Family Medicine	6/16/2014	6/30/2015	Yes	ACGME
Residency	2	Family Medicine	7/1/2015	6/30/2016	Yes	ACGME
Residency	3	Family Medicine	7/1/2016	6/30/2017	Yes	ACGME
Residency	4	Family Medicine	7/1/2017	6/30/2018	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: Joshua St. Louis

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:

Print Name: Wendy Barr, MD, MPH, MSCE

Academic Title: Program Director

Telephone: (978) 725-7410 Today's Date: 7/21/2017

E-mail address: wbarr@glfhc.org

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

Seal Verified
Date: 7/28/17
Initials: LA

PRINT NAME: Joshua St. Louis DATE: 7/3/17

FULL LICENSE APPLICATION SUPPLEMENT

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

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

PRINT NAME: Joshua St. Louis DATE: 7/3/17

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

PRINT NAME: Joshua St. Louis DATE: 7/3/17

CONFIDENTIAL INFORMATION

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

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

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

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

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

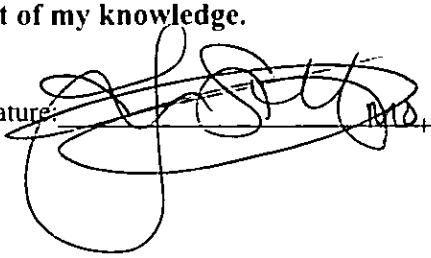
If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Joshua St. Louis DATE: 7 / 3 / 17

CERTIFICATIONS

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

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

Applicant's Signature:  Date: 7 / 3 / 17

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joshua H St. Louis, M.D. **License No.:** 273183

Current Status: Active **License Expiration Date:** 3/29/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Greater Lawrence Family Health Cener
34 Haverhill Street
Lawrence
Massachusetts - 01840
United States of America
(978) 686-0090

3) **Email Address:**

4) **Fax Number:** (978) 687-1947

5) **Specialties**
Family Medicine

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
Greater Lawrence Family Health Center	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 15 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Federal Tort Claims Act	06/16/2014	12/31/2018	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 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: Joshua H St. Louis, M.D. **License No.:** 273183

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.**

Date Received: 7/23/18

Check #: 277

Check Amount: $ 10.00

Initials: RF

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

RECEIVED JUL 23 2018

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: New Hampshire Board of Medicine

ADDRESS: 121 South Fruit Street

CITY: Concord STATE: NH ZIP: 03301

PHYSICIAN'S NAME: Jaime M. St. Louis, MD, MPH

BUSINESS ADDRESS: 34 Haverhill St.

CITY: Lawrence STATE: MA ZIP: 01840

MASSACHUSETTS LICENSE NUMBER: 273183

SIGNATURE OF PHYSICIAN: *Signed under the penalties of perjury*

DATE: 7/18/18

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joshua H St. Louis, M.D. **License No.:** 273183

Current Status: Active **License Expiration Date:** 3/29/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Greater Lawrence Family Health Cener
34 Haverhill Street
Lawrence
Massachusetts - 01840
United States of America
(978) 686-0090

3) **Email Address:**

4) **Fax Number:** (978) 687-1947

5) **Specialties**
Family Medicine
HIV and Viral Hepatitis

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
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
Greater Lawrence Family Health Center	

HealthQuarters Beverly

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 15 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Other	09/01/2019	09/01/2020	Occurrence Policy
Federal Tort Claims Act	01/01/2020	12/31/2020	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 engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?

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

26) Domestic Violence and Sexual Violence Training Requirement
Have you completed training and education on the issue of domestic violence and sexual violence? Yes

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: Joshua H St. Louis, M.D. **License No.:** 273183

☒ **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.**