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APR 8 2016
Board of Registration in Medicine

Application #: 267237
For Board Use Only

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
www.mass.gov/massmedboard

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $100.00 check payable to the Commonwealth of Massachusetts.

CHECK ONE: ☒ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
☐ Graduate of an International Medical School (IMG)

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS.

SECTION A: Sworn Statement to be completed by applicant

1-A. Name: (Last) Reisinger - Kindle (First) Keith (MI) M

1-B. Other Name(s) Keith Michael Reisinger II

	YES	NO
a) Since your graduation from medical school, have you ever been known under a different name or been licensed under a different name?	☐	☒
b) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☒

If you answer **yes**, you must provide additional information. (See instructions.)

2. Current Address: [redacted] Telephone Number: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]

3. Date of Birth: [redacted] (Month Day Year) Place of Birth: [redacted]

E-mail Address [redacted]

4. Sex: ☒ Male ☐ Female 5. U.S. Social Security Number: [redacted]

6. Name of Massachusetts Training Program: Baystate Medical Center

759 Chestnut Street (Street Address) Springfield (City)

Are you applying for licensure through the Federation Credentials Verification Service (FCVS)?
☐ Yes ☒ No

Date Received: 4 / 8 / 16

Check #: 10953706

Check Amount: $ 100.00

Initials: RF

PRINT NAME Keith Michael Reisinger -Kindle

7. Name of premedical school(s): University of Michigan

Location: Ann Arbor, MI, USA (City, State, Country)

8. Name of medical school(s): Touro University - Nevada

Location: Henderson, NV, USA (City, State, Country)

Date of Graduation: ~~05/15/16~~ 06 06 16 (Month Day Year) Degree: ☐ M. D. ☒ D. O. Other (specify)________

9. Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada?

☐ Yes ☒ No

Name of Postgraduate Training Program ____________________

City: ____________________ State: __________

Training Dates: From: __/__/____ To: __/__/____ Specialty: __________

(Attach a list of any additional postgraduate training in the United States or Canada.)

10. List states (abbreviations) where you ever had a full license to practice medicine.

N/A

11. Please indicate all the licensing examinations that you have have completed with a passing score:

USMLE: ☒ Step 1 ☒ Step 2 (CK) ☐ Step 2 (CS) ☐ Step 3

COMLEX: ☒ Level 1 ☒ Level 2 (CE) ☒ Level 2 (PE) ☐ Level 3

☐ LMCC ☐ Other ____________________

YES NO

12. If you are a U.S. 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? (Include leave of absence for research, public service, M.D./Ph.D program, and personal reasons, etc.) (Please request that your medical school also provide an explanation.)

13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? (Include past or current training programs)

PRINT NAME Keith Reisinger-Kindle

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Keith Reisinger-Kindle has been appointed
(Name of Applicant)

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the specialty of Obstetrics & Gynecology as a PGY 1

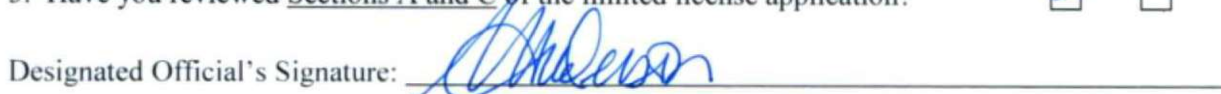
Department: Obstetrics & Gynecology Subspecialty: ____________

at Baystate Medical Center
(Name of Healthcare Facility)

beginning 07 / 01 / 2016 to anticipated completion of training: 07 / 01 / 2020
Month Day Year Month Day Year

	YES	NO
1. Is the program accredited by the ACGME?	☒	☐
2. If **no**, is there an ACGME-approved training program in the applicant's specialty?	☐	☐
3. Have you reviewed Sections A and C of the limited license application?	☑	☐

Designated Official's Signature:



Type or Print Name: Martha R. Anderson

Official Title: Manager, Graduate Medical Education

Date: 04/07/2016 Telephone Number: 4137948490

SECTION C: PAGES 4-7 MUST BE COMPLETED BY APPLICANT.

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, Keith Michael Reisinger-Kindle
(type or 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.

[signature] 3/23/16
Applicant's Signature Date of Signature

Keith Michael Reisinger-Kindle
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Keith M. Reisinger-Kindle, MPH, MS

Education

Touro University-Nevada — Henderson, Nevada
Doctor of Osteopathic Medicine — August 2012-June 2016

Touro University-Nevada — Henderson, Nevada
Master of Science: Health Sciences — June 2011-June 2012
Thesis: *Effects of Chronic Ang II Infusion on Tissue Levels of TNF-Alpha in WT Mice*

University of Michigan — Ann Arbor, Michigan
Master of Public Health: Health Behavior and Health Education — August 2009-April 2011
Global Health Graduate Certificate
Thesis: *Factors Involved in Patients' Expressed Gender Preferences in Abortion Providers*

University of Michigan — Ann Arbor, Michigan
Bachelor of Science: Anthropology-Zoology — August 2005-May 2009
Minors: Philosophy and Women's Studies (Gender and Health)

Kalamazoo Valley Community College — Kalamazoo, Michigan
EMT-Basic Certificate — June 2005-August 2005

Previous Employment Experience

Medical School Tutor — Henderson, Nevada
Touro University-Nevada — September 2013-Current

Cadaver Prosector, Anatomy Department — Henderson, Nevada
Touro University-Nevada — May 2013-July2013

Head Graduate Student Instructor — Ann Arbor, Michigan
Women's Studies Department, University of Michigan — August 2009-May 2011

Surgical Assistant — Ann Arbor, Michigan
Planned Parenthood — September 2006-April 2011

Assistant in Research, Program on InterGroup Relations — Ann Arbor, Michigan
Professor Kelly Maxwell — May 2008-July 2009

Clerk — Ann Arbor, Michigan
University of Michigan Health System — September 2007-April 2008

Student Scholar — San Jose, Costa Rica/Ann Arbor, Michigan
Global Intercultural Experience for Undergraduates — January-December 2007

Medical Research Assistant — Kalamazoo, Michigan
Bronson Methodist Hospital, Dr. Susan Hendricks-Perinatologist — June 2005-August 2006

Surgical Services Intern — Mattawan, Michigan
MPI Research — May 2005-August 2005

Keith M. Reisinger-Kindle, MPH, MS

Teaching Experience

Adjunct Lecturer — Spring 2015-Current
Valley Health System Family Medicine Residency

Adjunct Lecturer — Spring 2013-Current
Touro University-Nevada, College of Health and Human Services
-First student at Touro-Nevada to hold a teaching position while enrolled as a student

Women's Studies 220: Perspectives in Women's Health — Fall 2010-Winter 2011 (four semesters)
University of Michigan
Head Graduate Student Instructor/Graduate Student Instructor Mentor

Psych/Soc 122: Intergroup Dialogues (Gender) — Winter 2009
University of Michigan
Student Facilitator/Instructor

Leadership and Extra-Curricular Experience

Coalition Member — September 2014-Current
Nevada Teen Health and Safety Coalition

National Experienced Student Leaders Committee Member — September 2013-Current
Medical Students for Choice

National Healthcare Professionals in Training Committee Member — September 2012-Current
Gay and Lesbian Medical Association

Vice President (2013-2014), Executive Board Member (2011-2013)
Student Association of Obstetricians and Gynecologists

President (2012-2014) Member (2011-2012)
Gay and Lesbian Medical Association and Allies

President (2013-2014) Vice-President (2012-2013) and Secretary (2011-2012)
Medical Students for Choice

Presentations, Posters, and Publications

Plodkowski RA, McGarvey ME, Reisinger-Kindle K, et al. Obesity Management: Clinical Review and Update of the Pharmacological Treatment Options. 33(1):6-16; January 2016. *Fed Pract.*

Plodkowski RA, McGarvey ME, Huribal HH, Reisinger-Kindle K, et al. SGLT2 Inhibitors for the Treatment of Type 2 Diabetes Mellitus. Oct 2015. *Federal Practitioner.*

"Effectivity of Gastric Sleeve: A History and Review"
American Health and Drug Benefits, Submitted for Review.

"Pharmacological Methods for the Treatment of Obesity: A Review"
Federal Practitioner. Provisionally Accepted.

"Effects of Chronic Ang II Infusion on Tissue Levels of TNF-Alpha in WT Mice"
Draft in progress

"Transgender, Tranny, Crossdresser, and Transvestite: What It All Means and Why You Should Know" November 2012 and November 2013.
Lecture, Campus Community, Touro University-Nevada

"Birth Control Methods: Why Patients Choose" September 2013.
Lecture, Campus Community, Touro University-Nevada

"Reproductive Health: What Does Race Have to Do With It?" September 2012.
Lecture, Campus Community, Touro University-Nevada

"Factors Involved in Patients' Expressed Gender Preferences in Abortion Providers" October 2010.
Graduate Poster Session
Poster Presentation, School of Public Health, University of Michigan

"Unpacking the Knapsack: an Exploration of Privilege" March 2009.
Division of Student Affairs Conference, University of Michigan

Additional Training/Certifications

-Advanced Cardiac Life Support for Healthcare Providers. Completed February 2016.
-Basic Life Support for Healthcare Providers. Completed February 2016
-NIH: Protecting Human Research Participants Training/Certification. Completed November 2010

Professional Membership

-Sigma Sigma Phi Osteopathic Honors Fraternity	February 2013-Current
-Student Chairman's Club, OPAC Member	January 2013-Current
-American Public Health Association, Member	September 2012-Current
-American Medical Association, Member	August 2012-Current
-Gay and Lesbian Medical Association, Member	August 2012-Current
-Nevada Osteopathic Medical Association, Member	August 2012-Current
-Clark County Medical Society, Member	August 2012-Current
-Nevada State Medical Association, Member	August 2012-Current
-Student Osteopathic Medical Association, Member	August 2012-Current
-American Osteopathic Association, Member	August 2012-Current
-American College of Osteopathic Obstetricians and Gynecologists, Member	August 2012-Current
-American Medical Student Association, Member	July 2012-Current
-American Congress of Obstetricians and Gynecologists, Member	July 2012-Current

Grants and Awards

-Lance Karagiozis Scholarship for LGBT Health (2015)
-Student Doctor of the Year Award (2013)

-This award is given to one medical student from each osteopathic medical school for commitment to the profession, bettering the community, and overall achievement. The awardee is selected by a committee including the Dean, faculty, and students from each class.

-Medical Students for Choice's grant for funding to attend Abortion Training Institute (2013)
-Touro University-Nevada's Student Leadership and Service Award (2013)
-This award is given to one medical student each year for outstanding commitment to campus leadership and community service.
-T.O.U.C.H. Gold Award for 100+ community service hours in an academic year (2013 and 2014)
-Touro University-Nevada Student Research Grant (2012)
-Social Justice Honorary Cords for Social Justice Activism (2009 and 2011)
-Patricia Gurin Certificate of Merit for completion, with distinction, of advanced study of intergroup relations and social justice education (2009)
-LSA Dean's Scholarship (2008)
-Two-Time National Ballroom Dancing Collegiate Champion (2005 and 2006)
-Michigan Merit Scholarship (2005-2006)

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: [signature] Date of Birth: [redacted]

Print or Type Name: Reisinger-Kindle (Last Name) Keith (First Name) M (Middle Initial) U.S. Social Security No [redacted]

Other Name(s): Keith M. Reisinger II (Please type or print.)

Name of Medical School: Touro University - Nevada

Address: 874 American Pacific Drive City: Henderson State or Province: NV

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Michigan - Ann Arbor

Undergraduate School Address: 500 S State St. Ann Arbor, MI 48109

Enrollment and Participation: Our records indicate that (print the applicant's name): Reisinger-Kindle (Last name) Keith (First name) M. (Middle initial)

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 / 8 / 12	5 / 24 / 13	7 / 1 / 15	4 / 30 / 16
	8 / 5 / 13	5 / 23 / 14	/ /	/ /
	7 / 1 / 14	6 / 30 / 15	/ /	/ /

Seal Verified
DATE: 4-12-16
INITIALS: CM

The applicant attended 180 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 D.O. on (month/day/year) ___/___/___

☒ will be awarded on 6 / 6 / 16 (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: Rochelle Grantz

Print Name: Rochelle Grantz

Title: Enrollment Counselor

Date: 3 / 23 / 16 Telephone: (702) 777-3954

E-mail address: rochelle.grantz@tun.touro.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.

PRINT NAME Keith Michael Reisinger-Kindle

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement. You must answer all questions or your application will be returned to you.

YES NO

14. 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.)

    If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.

15. 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?

16. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?

    If you answered "yes" to 15 or 16, you must provide an explanation and request a letter of explanation from your medical school, graduate school, or postgraduate training program.

17. 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?

18. Have you ever been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?

19. 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.)

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. 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?

PRINT NAME Keith Michael Reisinger-Kindle

	YES	NO
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. Have you ever relinquished any medical staff membership or association with a health care facility?		
25. 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?		
26. 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.)		
27. 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?		
28. Has any medical malpractice claim 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?		
29. 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?		
30. 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?		
31. 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 Keith Michael Reisinger-Kindle

CONFIDENTIAL MEDICAL INFORMATION

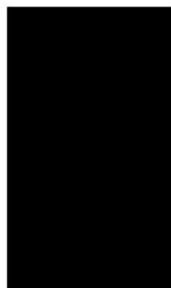
Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or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

YES **NO**

32. Do you have a medical or physical condition that currently impairs your ability to practice medicine?

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

34. 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 15-34 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

PRINT NAME Keith Michael Reisinger-Kindle

CERTIFICATIONS

- 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 and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00.
- To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license 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.

Applicant's Signature: [signature] Date: 03/23/16

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 Keith M. Reisinger-Kindle
(Student's Name)

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

from Touro University Nevada College of Osteopathic Medicine
(Name of Medical School)

and will receive the degree on 6 / 06 / 16.

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

Printed Name: Rochelle Grantz

Title: Enrollment Counselor

Date: 5/20/16

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

Thank you.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

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1. Training Program

Current Training Program

Facility: Baystate Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address:
Baystate Medical Center
759 Chestnut Street
Springfield
Massachusetts - 01199
United States of America

Home Address:

3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 267237

5. Other states where you are now licensed to practice medicine
None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? ____

Has the physician been subject to past or pending disciplinary action in this Program? ____

Name: ____________________ **Date:** ____________________
Designation: ____________________ **Telephone:** ____________________

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that ______________________________ has been appointed as ______________

Department of ___________

Is the program accredited by the ACGME: ____

Designated Official's Name: ____________________ **Date:** ____________________
Designated Official's Title: ____________________ **Telephone:** ____________________

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim 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?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

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

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

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

[X] **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

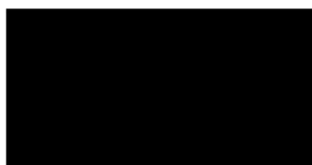
1. **Training Program**

   Current Training Program

   Facility: Baystate Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address: Baystate Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   Home Address: 

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 267237

5. **Other states where you are now licensed to practice medicine**
   None Reported

   SECTION B: To be completed by the Program Director.

   Is the above named physician in good standing in the training program?

   Has the physician been subject to past or pending disciplinary action in this Program?

Name:	Donald Kirton	**Date:**	1/30/2017
Designation:	Program Director	**Telephone:**	(413) 794-5321

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Keith M Reisinger-Kindle** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name:	Martha Anderson	**Date:**	2/9/2017
Designated Official's Title:	GME Registrar	**Telephone:**	(413) 794-8490

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim 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?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

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

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

Compliance with Legal Responsibilities

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3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

☒ **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

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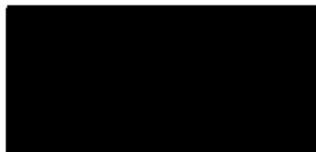
1. Training Program

Current Training Program

Facility: Baystate Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: Baystate Medical Center
759 Chestnut Street
Springfield
Massachusetts - 01199
United States of America

Home Address: 

3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 267237

5. Other states where you are now licensed to practice medicine
None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? ____

Has the physician been subject to past or pending disciplinary action in this Program? ____

Name: ______________________ **Date:** ____________________
Designation: ______________________ **Telephone:** ____________________

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that ______________________ has been appointed as ______________

Department of ___________

Is the program accredited by the ACGME: ____

Designated Official's Name: ______________________ **Date:** ____________________
Designated Official's Title: ______________________ **Telephone:** ____________________

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim 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?

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4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
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9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

☒ **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

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1. Training Program

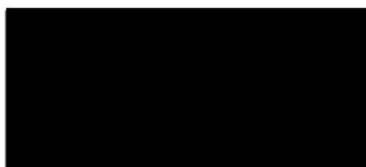
Current Training Program

Facility: Baystate Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: Baystate Medical Center
759 Chestnut Street
Springfield
Massachusetts - 01199
United States of America

Home Address:



3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 267237

5. Other states where you are now licensed to practice medicine
None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program?

Has the physician been subject to past or pending disciplinary action in this Program?

Name: Donald Kirton **Date:** 2/20/2018
Designation: Program Director **Telephone:** (413) 794-5321

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Keith M Reisinger-Kindle** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Martha Anderson **Date:** 3/8/2018
Designated Official's Title: GME Registrar **Telephone:** (413) 794-8490

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

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

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

18. Has any medical malpractice claim 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?

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4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
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9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

[X] **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

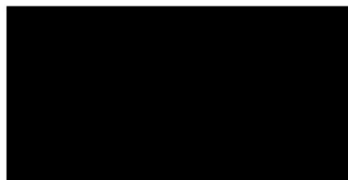
1. **Training Program**

   Current Training Program

   Facility: Baystate Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address: Baystate Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   Home Address: 

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 267237

5. **Other states where you are now licensed to practice medicine**
   None Reported

   SECTION B: To be completed by the Program Director.

   Is the above named physician in good standing in the training program? ____

   Has the physician been subject to past or pending disciplinary action in this Program? ____

   Name: ______________________ **Date:** ______________
   Designation: ______________________ **Telephone:** ______________

   To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

   This certifies that ______________________ has been appointed as ______________

   Department of ____________

   Is the program accredited by the ACGME: ____

   Designated Official's Name: ______________________ **Date:** ______________
   Designated Official's Title: ______________________ **Telephone:** ______________

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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

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14. Have you voluntarily relinquished medical staff membership?

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

22. **MassHealth Enrollment Status**
I am already enrolled with MassHealth as a nonbilling provider.

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to M.G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
2. I certify that I have complied 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.
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9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. 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.
12. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

[X] **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Limited Renewal Application

Physician Name: Keith M Reisinger-Kindle, D.O. **License No.:** 267237

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1. Training Program

Current Training Program

Facility: Baystate Medical Center
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: Baystate Medical Center
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Home Address:

3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 267237

5. Other states where you are now licensed to practice medicine
None Reported

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program?

Has the physician been subject to past or pending disciplinary action in this Program?

Name: Donald Kirton **Date:** 1/18/2019
Designation: Program Director **Telephone:** (413) 794-5321

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that **Keith M Reisinger-Kindle** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Martha Anderson **Date:** 1/30/2019
Designated Official's Title: Manager, Graduate Medical Educ **Telephone:** (413) 794-8490

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

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8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?

9. Have you voluntarily surrendered a license to practice medicine or any healing art?

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).

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

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim 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?

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

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

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

22. MassHealth Enrollment Status
I am already enrolled with MassHealth as a nonbilling provider.

Compliance with Legal Responsibilities

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

2. I certify that I have complied 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.

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112, sec. 12A ½.

5. I certify that I have complied 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 person violated any provisions of M.G.L. c. 112, sec. 5 or any Board regulation.

6. I certify that I have complied 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.

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. 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.

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

[X] **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

RECEIVED
FEB 10 2020
Board of Registration in Medicine

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

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: State Medical Board of OHIO

ADDRESS: 30 East Broad Street, 3rd Floor

CITY: Columbus STATE: OH ZIP: 43215

PHYSICIAN'S NAME: Keith Reisinger-Kindle

BUSINESS ADDRESS: 759 Chestnut St.

CITY: Springfield STATE: MA ZIP: 01199

EMAIL ADDRESS: [redacted]

MASSACHUSETTS LICENSE NUMBER: 267237

SIGNATURE OF PHYSICIAN: [signature]

DATE: 2/7/2020 *Signed under the penalties of perjury*

Date Received: 2/10 Feb 20
Check #: 133
Check Amount: $ 10.00
Initials: RF

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

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

PHYSICIAN LICENSE VERIFICATION REQUEST

INSTRUCTIONS

REQUESTS FOR REVIEW OF COMPLAINT FILES MUST BE ACCOMPANIED BY A WAIVER FORM PROVIDED BY THE BOARD OF REGISTRATION IN MEDICINE. ***NO OTHER FORMS WILL BE ACCEPTED.***

The attached Waiver for Release of Information form must be completed as directed and signed by the physician requesting a License Verification, Certified Statement, or Letter of Good Standing (all are considered the same form).

The fee for completing a License Verification, Certified Statement, or Letter of Good Standing is $10.00 (ten dollars) per verification request. (Full License verifications and Limited License verifications are separate requests; the fee for each license verification is $10.00.)

Please make your check or money order payable to the **Commonwealth of Massachusetts** and forward it to the address below. **We cannot accept cash payment**.

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

License Verification requests will not be processed if the waiver form is substituted or incomplete, or if the $10.00 processing fee for each license verification request is not included.

Please include a stamped envelope with the name and address of the recipient. If you wish to have the verification sent via overnight delivery, please include a prepaid USPS envelope. We cannot send the requests via UPS or FedEx.

Please allow at least three (3) weeks for processing of license verification requests.

NOTICE TO THE APPLICANT

THIS REQUEST IS BEING RETURNED FOR THE FOLLOWING REASON(S):

- **The Board's waiver form is not included**
  The $10.00 fee has not been received and/or is incorrect