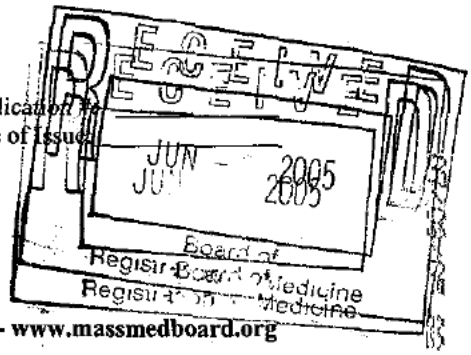
DA 618105 331

226818 618105 Application # Date of Issue



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

FULL LICENSE APPLICATION

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

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

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

FERZANDI TANAZ R.

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

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

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

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

Date of Birth: [redacted] Social Security Number: [redacted]
Month Day Year

Place of Birth: [redacted]
City State/Province/Territory Country if not USA

Home Address: [redacted]
[redacted]
City State/Province/Territory Zip (or postal) Code

Business Address: 330 BROOKLINE AVE
Number and Street

BOSTON MA. 02215
City State/Province/Territory Zip (or postal) Code

Business Telephone: (617) 667-2285 ext. _____ Home Telephone: [redacted]

E-mail Address [redacted]

Preferred Mailing Address: ☐ Business Address ☒ Home Address

PRINT NAME: TANAZ R. FERZANDI PAGE 2 OF 3

Pre-medical School

			From	To
Facility: UNIV. OF KANSAS	Degree: BA		08/__/1984	01/__/1989
Street: _____	City: LAWRENCE	State: KS.		
Facility: UNV OF KANSAS MED CTR	Degree: MA		8/__/90	5/__/95
Street: 3901 RAINBOW BLVD	City: KANSAS CITY	State: KANSAS		

Medical School

			From	To
Facility: UNIV KANSAS MED CTR	Degree: MD		8/__/97	5/__/2001
Street: _____	City: KANSAS CITY	State: KANSAS		
Facility: _____	Degree: _____		__/__/__	__/__/____
Street: _____	City: _____	State: _____		

Date of medical school graduation: 05 / 20 / 2001

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

Postgraduate Education:

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

			From	To
Facility: BETH ISRAEL DEACONESS	Position: PGY-1		6/__/01	6/__/02
Street: 330 BROOKLINE AVE	City: BOSTON	State: MA		
Facility: BETH ISRAEL DEACONESS	Position: PGY-2		6/__/02	6/__/03
Street: 330 BROOKLINE	City: BOSTON	State: MA		
Facility: BETH ISRAEL DEACONESS	Position: PGY-3		6/__/03	6/__/04
Street: 330 BROOKLINE	City: BOSTON	State: MA		
Facility: BETH ISRAEL DEACONESS	Position: PGY-4		6/__/04	6/16/05
Street: 330 BROOKLINE AVE	City: BOSTON	State: MA		
Facility: _____	Position: _____		__/__/__	__/__/____
Street: _____	City: _____	State: _____		

PRINT NAME: TANAZ R. FERZANDI PAGE 3 OF 3

Hospital Affiliations and Employment

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

		From	To
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		

1. List other states (abbreviations) where you are currently or have ever been licensed: _____ _____ _____
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): _____ Certification date: __/__/__

   _____ Certification date: __/__/__
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: BEGIN PRACTICE/ FELLOWSHIP IN UROGYNECOLOGY
6. Name of Facility: MOUNT AUBURN
7. Address: 330 MT AUBURN STREET City: CAMBRIDGE
8. Anticipated starting date in Massachusetts: 7/1/05

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

Signature of Applicant MD — Date 4/25/05

Rev: 10/21/2002

Authorization for NPI Dissemination

I authorize the Board of Registration in Medicine to provide my NPI to any authorized agency, hospital, health plan, or health organization.

Signature: Jfernandes Date: 11 / 20 / 06

License Number: 226218

Fields, Ray (DPH)

From: [redacted]
Sent: Tuesday, June 28, 2005 11:46 AM
To: webmaster@massmedboard.org
Subject: www.massmedboard.org - Physician Address Change

Last_Name = Ferzandi

First_Name = Tanaz

email = [redacted]

Board_Number = 226218

DOB = [redacted]

M_Address1 = [redacted]

M_City = [redacted]

M_State = [redacted]

M_Zip = [redacted]

M_Country = [redacted]

M_Phone = [redacted]

B_Address1 = 725 Concord Avenue, St. 3300

B_City = Cambridge

B_State = MA

B_Zip = 02138

B_Country = USA

B_Phone = 617-354-5452

H_Address1 = [redacted]

H_City = [redacted]

H_State = [redacted]

H_Zip = [redacted]

H_Country = [redacted]

H_Phone = [redacted]

07-09-05 22 4

RECEIVED
JUN 5 2001
BOARD OF REGISTRATION IN MEDICINE

LIMITED LICENSE APPLICANT

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

MEDICAL EDUCATION VERIFICATION

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

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: Tanaz R. Ferzandi. Date of Birth [redacted]

Print or Type Name: FERZANDI (Last name) TANAZ (First Name) R. (Middle Initial) Social Security No: [redacted]

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

Name of Medical School: UNIVERSITY OF KANSAS

Address: 3901 RAINBOW BLVD. City: KANSAS CITY State or Province: KANSAS

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) to the applicant. 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? [X] Yes [ ] No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Kansas

Undergraduate School Address: Lawrence, Kansas

Continued on page 2

LIMITED LICENSE APPLICANT

Enrollment and Participation: *Our records indicate that*

Ferzandi, Tanaz R.

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

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	08 / 11 / 97	04 / 21 / 01	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

The applicant attended 144 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one [X] was awarded a degree in Doctor of Medicine on (month/day/year) 05 / 20 / 01

[ ] was NOT awarded degree. Please explain reason(s).

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

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?	[redacted]	
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Anne G Flaherty

Print Name: Anne G. Flaherty

Title: Assistant Dean of Students/Registrar

Date: 05 / 30 / 01 Telephone: (913) 588-6593

Seal Verified

DATE: 6/05

INITIALS: CH

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

Commonwealth of Massachusetts--Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118

MEDICARE - TAX FORM

INSTRUCTIONS:

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

I, TANAZ R. FERZANDI,
(type or print name)

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

SIGNED: Ferzandi DATE: 4/25/05

Social Security Number: [redacted]

****

Massachusetts General Laws Chapter 112, §5, and 243 CMR 2.04 (2) (k) require that you complete the following statement:

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

SIGNED: Ferzandi DATE: 4/25/05

Revised 10/10/2002

Commonwealth of Massachusetts--Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

ed.

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

TANAZ FERZANDI MD
(name of applicant)

for 3.5 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.

Tanaz R. Ferzandi
Signature of applicant

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

Young Bin Kim
Signature of Certifying Physician

75710 MA
License Number State

Young B. Kim, M.D.
Type or print name clearly

Director, Division of Gynecologic Oncology
Beth Israel Deaconess Medical Center
Address: 330 Brookline Avenue
City: Boston, MA 02215
State: Zip:
Telephone: (617) 667-4040
Date: 4/28/05
(617) 667-4747 fax

Signature of Notary

8/29/08
My commission expires

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

Seal Verified
DATE: 6/05
INITIALS: CH

MALPRACTICE HISTORY

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

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

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

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

Liability Carrier: CRICO **From:** 6/2001 **To:** 7/2005
City: BOSTON State: MA Policy Number: _____

Liability Carrier: _____ **From:** ___/___ **To:** ___/___
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ **From:** ___/___ **To:** ___/___
City: _____ State: _____ Policy Number: _____

Applicant's signature: Tanaz R. Ferzandi 6/22/05
Date

Print Name: TANAZ R. FERZANDI

Address: [redacted] City: [redacted]

State: [redacted] Zip code: [redacted]

Additional forms available at the Board's website at www.massmedboard.org

DR
05/14/01
Ch# 0592

RECEIVED
MAY 11 2001
BOARD OF REGISTRATION IN MEDICINE

Application #: 211537
Date Approved: ____/____/____

Commonwealth of Massachusetts- Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111 - www.massmedboard.org

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

- [X] Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- [ ] Graduate of an International Medical School (IMG)
- [ ] Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) FERZANDI (First) TANAZ (MI) R.

1-B. Other Name(s): _____

1-C. Mother's Maiden Name: SAGAR

	YES	NO
1) Have you ever been known under a different name or combination of names?	[ ]	[X]
2) Have you ever been licensed under a different name?	[ ]	[X]
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	[ ]	[X]

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

2. Current Residence: [redacted] Telephone Number: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

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

4. Sex: [ ] Male [X] Female 5. Social Security Number: [redacted]

6. Name of Massachusetts Training Hospital: BETH ISRAEL DEACONESS

330 BROOKLINE AVE, BOSTON, MA 02215
(Street Address) (City)

PRINT NAME TANAZ R. FERZANDI

7. Name of premedical school(s): UNIVERSITY of KANSAS

Location: LAWRENCE, KS. USA
(City, State, Country)

8. Name of medical school(s): UNIV. OF KANSAS

Location: KANSAS CITY, KS. USA
(City, State, Country)

Date of Graduation: 05 / 19 / 01 (Month) (Day) (Year) Degree: ☒ M. D. ☐ D. O. Other(specify)_____

9. Have you had previous post-graduate training? ☒ No ☐ Yes ☐ U.S. or ☐ International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *currently* have a license to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or training license (L).

____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency-training licenses). Indicate whether full license (F) or residency or limited license (L).

____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

	YES	NO
12-A. If you are a USMG, have you taken more than 4 years to complete medical school?		[redacted]
12-B. If you are an IMG, have you taken more than 6 years to complete medical school? If yes, you must provide additional information. (See instructions).		
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? If yes, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)		

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

This certifies that Tanaz Ferzandi has been appointed
(Name of Applicant)

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the specialty of OB/GYN as a PGY 1

Department: OB/GYN Subspeciality: _____

at Beth Israel Deaconess medical Center
(Name of Healthcare Facility)

beginning 06/12/01 (Month) (Day) (Year) to anticipated completion of training: 06/30/05 (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: _____ MD

Type or Print Name: Jodi Abbott, (MD)

Official Title: Director

Date: 4/30/01 Telephone Number (617) 667-2285

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

PRINT NAME: TANAZ R. FERZANDI

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.

	YES	NO
14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).		[redacted]
If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.		
15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16-A. Have you ever been terminated by a medical school or postgraduate training program?		
16-B. Have you ever been granted a leave of absence by a medical school or a postgraduate training program?		
16-C. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?		
If you answered "yes" to 16-A, B or C, a letter from your medical school(s) or postgraduate training program(s) is required.		
17. Since your enrollment in college, 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?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		

PRINT NAME: TANAZ R. FERZANDI

		YES	NO
20.	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).		[redacted]
21.	Has any disciplinary action ever 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).		
22.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you ever voluntarily relinquished medical staff membership?		
25.	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?		
26.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: TANAZ R. FERZANDI

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
30.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		[redacted]
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 15-35 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.

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.

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

Applicant's Signature: Tanaz R. Ferzandi **Date:** 04/06/01

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
10 WEST STREET, BOSTON, MA 02111 - (617) 727-3086

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, TANAZ R. FERZANDI
(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
10 West Street, Boston, MA 02111
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 enveloped and that none of the seals have been broken.

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.

Tanaz R. Ferzandi
Applicant's Signature

04-12-01
Date of Signature

FERZANDI, TANAZ R.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

TANAZ R. FERZANDI - CURRICULUM VITAE

[redacted]

PERSONAL

Date of Birth:
Telephone:
E-mail:

[redacted]

EDUCATION

Candidate for Doctor of Medicine
University of Kansas Medical Center, August 1997 to May 2001
Master of Arts, Cell Biology
University of Kansas Medical Center, May 1995
Bachelor of Arts, Biology
University of Kansas, Lawrence, Kansas, January 1989

PUBLICATIONS/THESIS

"Thapsigargin shifts the Ca^{++} Set Point of Parathyroid Cells to Lower Extracellular [Ca]." *Endocrine* Journal, Dec. 1997.
"The Effect of Thapsigargin on the Secretion of Parathyroid Hormone from Parathyroid Glands." Master's Thesis, 1995.
"The Effect of Thapsigargin on PTH Secretion." Abstract and Poster Presentation, American Society of Cell Biology, Dec. 1993.
"PTH Secretion and Thapsigargin." Abstract and Poster Presentation, Ninth Int'l Meeting of Endocrinology, Sept. 1992.

HONORS AND SCHOLARSHIPS

Frank Dewitt Bennett Scholarship, 2000
RM Gouldner Medical Scholarship, 1999
Dr. Thornton L. Waylan Scholarship, 1999
Leslie Friend Dalton Foundation Scholarship, 1997
"Honorary Mention" Award, 22nd Annual Student Research Forum, University of Kansas Medical Center, 1994
Research Travel Scholarship, University of Kansas Medical Center, 1993 and 1992

CONFERENCES

Kansas City Gynecological Society Meeting, Kansas City, Missouri, May 2000.
Kansas Association of Family Practice, Kansas City, Missouri, 1998
22nd Annual Student Research Forum, University of Kansas Medical Center, 1994
Meeting of the American Society of Cell Biology, New Orleans, Louisiana, 1993
Ninth International Meeting of Endocrinology, Nice, France, 1992

ACTIVITIES AND ORGANIZATIONS

Medical School:

- Wahl Academic Society
- American Heart Association Screening Volunteer
- Student Representative – Microbiology Curriculum
- Rosedale Community Outreach Project Volunteer
- Conversational Spanish Group - UMKC
- American Medical Association
- American Medical Women's Association
- American Medical Students Association
- Zoroastrian Association of Kansas

Undergraduate:

- Overland Park Medical Center ER Volunteer
- Ronald McDonald House Charities
- United Way of Lawrence
- University of Kansas Governing Student Council
- Zoroastrian Association of Kansas
- Alpha Delta Pi Sorority

WORK EXPERIENCE

Shook, Hardy & Bacon Law Firm, Kansas City, Missouri. Research Analyst, 1996-1997.
Wisap/Market-Tiers, Inc., Lenexa, Kansas. FDA Liaison, 1995-1996.
Worthington Biochemical, New Jersey. Research Assistant for Development of Hepatocyte Culture Kits, 1992-1994.
Shook, Hardy & Bacon Law Firm, Overland Park, Kansas. Part-time Legal Assistant, 1987-1997.

The University of Kansas Medical Center

April 20, 2001

RE: TANAZ FERZANDI
SSN #: [redacted]

TO WHOM IT MAY CONCERN:

This is to certify that TANAZ FERZANDI entered the University of Kansas School of Medicine August 11, 1997, and is currently enrolled in the FOURTH year of a four year medicine program. She will be enrolled fulltime from 7/3/00 until 4/21/01. She is scheduled to complete requirements for graduation on 4/21/2001. Tanaz is then scheduled to be awarded the degree Doctor of Medicine at the next regularly scheduled commencement date for the University of Kansas. (May 20, 2001)

Sincerely,

Anne J. Flaherty

Anne Flaherty
Assistant Dean of Students / Registrar

Division of Student Services 3901 Rainbow Blvd., Kansas City, Kansas 66160-7190 • (913) 588-7055

Student Financial Aid 588-5170	Registrar 588-7055	Student Counseling & Academic Services 588-6580	Student Health 588-1941	Student Resources/ Wellness/Diversity 588-6681	Student Administration System 588-4691	Kirmayer Fitness Center 588-7701

The University of Kansas

University Registrar

Date: 05/01/01
Ctrl No: 010501 7428 001

PAT HESS
OFFICE OF THE REGISTRAR
UNIVERSITY OF KANSAS MED. CTR.
39TH AND RAINBOW BLVD
KANSAS CITY KS 66160-7191
913-588-7055

We are providing the enclosed transcript as requested.

Requested by: FERZANDI TANAZ R

Copies: 01
Delivery: C

Name on Record: FERZANDI TANAZ R
* Current Name:
* Social Security Number: [redacted]
* Date of Birth:

* Self-reported information

Sincerely,

Richard C. Morrell

Richard C. Morrell
University Registrar

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

June 20, 2005

Tanaz R Ferzandi, M.D.
Mount Auburn Hospital
330 Mount Auburn Street
Cambridge, Massachusetts 02138

Re: Application Number 226218

Date Application Received: 06/08/2005

Dear Dr. Ferzandi :

Your application for a full medical license in Massachusetts was received on the above date.

The Licensing Unit will assist you in expediting the processing of your application, however, please be advised that it can take up to twelve (12) weeks to process an application. Throughout this process, we will provide you with periodic updates regarding the status of your license application.

You will receive a notification of missing documents for your full license application in four weeks. Please be advised that if your full license application is incomplete after 6 months, you will be required to update the application and specific documents that are 6 months old. For additional licensing information, you may access the Board's website at www.massmedboard.org .

Sincerely,

Licensing Staff

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

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

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

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

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Applicant's signature: _____ ____/____/____
Date

Print Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

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

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

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

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

Liability Carrier: _____ **From:** ____/____ **To:** ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ **From:** ____/____ **To:** ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ **From:** ____/____ **To:** ____/____
City: _____ State: _____ Policy Number: _____

Applicant's signature: _____ ____/____/____
Date

Print Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: Tanaz R. Ferzandi MD. Date: 3/25/2005

Print or Type Name: TANAZ R. FERZANDI, MD

Name of Institution: Beth Israel Deaconess Medical Ctr.

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Beth Israel Deaconess Medical Ctr

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

Enrollment and Participation: Our records indicate that TANAZ R. FERZANDI, MD participated in the following program:
(Print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
internship	1	OB/Gyn	6/17/01	6/30/02	Y	ACGME
residency	2	OB/Gyn	7/1/02	6/30/03	Y	ACGME
residency	3	OB/Gyn	7/1/03	6/30/04	Y	ACGME
chief year	4	OB/Gyn	7/1/04	6/10/05	Y	ACGME

(Continued on page 2)

POSTGRADUATE VERIFICATION FORM PAGE - 2

APPLICANT'S NAME: Tanaz R. Ferzandi, M.D.

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

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

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

COMMENTS:_____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: [signature]

Print Name: Hope Ricciotti, M.D.

Academic Title: Resident Director

Telephone: (617)667-2285 Today's Date: 3/28/05

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

Seal Verified

DATE: 6/6/05

INITIALS: CH

SUPPLEMENT FORM

PRINT NAME: TANAZ R. FERZANDI DATE: 4/25/05

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

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

Applicant's Signature: Tferzandi Date: 4/25/05

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?	[redacted]	
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: _____ **Date:** 4/25/05

CONFIDENTIAL MEDICAL INFORMATION

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

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

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

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

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

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

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

I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Applicant's Signature: _____ **Date:** 4/25/05

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE

560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 www.massmedboard.org

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, TANAZ R. FERZANDI
(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
560 Harrison Avenue, Suite #G-4
Boston, Massachusetts 02118
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.

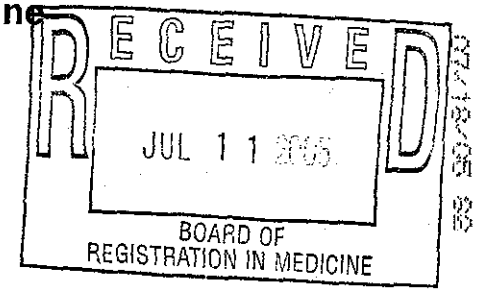
A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Tferzandi — 4/25/05
Applicant's Signature — Date of Signature

FERZANDI, TANAZ R.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Massachusetts
Board of Registration in Medicine
Physician Profile



This Profile is not available for public release until 07/13/2005.

TANAZ R FERZANDI MD

226218

I. Physician Information

(The information in sections I - V has been provided by the physician.)

License Status:	Active
License Issue Date:	06/27/2005
Accepting New Patients:	No
Accepts Medicaid:	No
Primary Work Setting:	None Reported
Business Address:	~~Mount Auburn Hospital~~, ~~Dept of Ob/Gynecology~~ Boston Urogynecology Assoc ~~330 Mount Auburn Street~~ 725 Concord Ave, # 3300 ~~CAMBRIDGE, MA 02138~~ Cambridge, MA 02138
Phone:	~~None Reported~~ 617-354-5452
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospitals:	None Reported

Commonwealth of Massachusetts
Board of Registration in Medicine

560 Harrison Avenue, Boston, Massachusetts 02118
Telephone (617) 654-9810 www.massmedboard.org

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: MEDICAL STAFF SERVICES
NEWTON-WELLESLEY HOSPITAL

ADDRESS: 2014 WASHINGTON STREET
NEWTON, MA 02462

CITY: _____ STATE: _____ ZIP: _____

(TYPE OR PRINT) PHYSICIAN'S NAME: TANAZ R. FERZANDI

BUSINESS ADDRESS: 725 CONCORD AVE STE #3300

CITY: CAMBRIDGE STATE: MA ZIP: 02138

MASSACHUSETTS LICENSE NUMBER: 226218

SIGNATURE OF PHYSICIAN: Ferzandi

Signed under the penalties of perjury

DATE: 6-15-05

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

RECEIVED JUL 11 2005 Board of Registration in Medicine

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi **License No.:** 226218

12/20/05 991

PART A

1) Current Status: Active **Renewal Due Date:** 12/25/2005 **Birth Date:** [redacted]

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

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

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

2a) MAILING ADDRESS

[redacted]

RECEIVED
DEC 19 2005
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

[redacted]

Phone: [redacted]

RECEIVED
DEC 29 2005
Board of Registration in Medicine

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___)_____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Boston Urogynecology Assoc.
725 Concord Ave Ste 3300
Cambridge, MA 02138

Phone: (617)354-5452

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___)_____

Business address cannot be a Post Office Box

3) E-mail Address: [redacted]

4) Fax Number: 617-497-7503

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi **License No.: 226218**

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

a) Massachusetts: [redacted]

b) Federal (DEA):

c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

8b) States where you were previously licensed (Abbr.)

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

Principal Work Setting: Hospital Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 15 as of 12/26/05

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

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Beth Israel Deaconess Hospital	☐	Admitting		10
Mount Auburn Hospital	☐	Admitting		30
Tufts - New England Medical Center Hospitals	☐	Admitting		10
Newton/Wellesley Hospital	☐	Admitting		0-2
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: 5 hrs/wk

b) outpatient care 0 hrs/wk Change to: 10 hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO (GILPL - 9/06 - 2005) Change to: MTAH - CRICO - C-GLPL-10/2-2006

Policy dates: From 10/30/05 To 12/31/05 *(required)*

policy period: 1/1/06 - 12/31/06

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi **License No.: 226218**

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

	YES	NO
23) Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (see Renewal Instructions, page 9.)		[redacted]

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

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

Signature: Tanaz R. Ferzandi Date: 11/10/05

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi **License No.: 226218**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Tanaz R. Ferzandi Date: 11 / 10 / 05

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi **License No.: 226218**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

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

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

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

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

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

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

☒ My current NPI is: 1 9 5 2 3 0 2 7 5 6

☐ I have personally applied for an NPI.

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

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

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	_____

NPI REQUIRED INFORMATION

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

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

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

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Signature: Tanaz R. Ferzandi Date: 11/10/2005

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

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, Boston, Massachusetts 02118
Telephone (617) 654-9810 www.massmedboard.org

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE VERIFICATION TO: MEDICAL STAFF SERVICES
NEWTON-WELLESLEY HOSPITAL

ADDRESS: 2014 WASHINGTON STREET
NEWTON, MA 02462

CITY: _____ STATE: _____ ZIP: _____

(TYPE OR PRINT)
PHYSICIAN'S NAME: Tanaz R. Ferzandi, M.D.

BUSINESS ADDRESS: Boston Urogynecology Associat
725 Concord Ave. #3300
Cambridge, MA 02138

CITY: _____ STATE: _____ ZIP: _____

MASSACHUSETTS LICENSE NUMBER: 226218

SIGNATURE OF PHYSICIAN: Tferzandi

Signed under the penalties of perjury

DATE: 6-15-06

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

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4, Boston, Massachusetts 02118
Telephone (617) 654-9830

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Newton-Wellesley Hospital – Medical Staff Services

ADDRESS: 2014 Washington Street

CITY: Newton STATE: MA ZIP: 02462

(TYPE OR PRINT)
PHYSICIAN'S NAME: TANAZ FERZANDI, M.D.

BUSINESS ADDRESS: 725 Concord Ave # 3300

CITY: Cambridge STATE: MA ZIP: 02138

MASSACHUSETTS
LICENSE NUMBER: 226218

SIGNATURE OF PHYSICIAN: Ferzandi MD
Signed under the penalties of perjury

DATE: 08-08-2007

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

PART A

1) Current Status: Active **Renewal Due Date:** 12/25/2007 **Birth Dat** [redacted]

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

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

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

2a) MAILING ADDRESS

[redacted]

RECEIVED
DEC 6 2007
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

[redacted]

Phone: [redacted]

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Boston Urogynecology Assoc.
725 Concord Ave Ste 3300
Cambridge, MA 02138

Phone: (617)354-5452

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: [redacted]

4) Fax Number: 617-497-7503

Correct your E-mail and Fax Number below:

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

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

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology		General Certification 2007	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.: 226218**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: [redacted]

b) Federal (DEA): [redacted]

c) Federal (DEA) XS:

Please make corrections as necessary

8) Other states where you are now licensed to practice

ϕ

9) States where you were previously licensed

ϕ

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Mount Auburn Hospital	Cambridge	MA	☐
Newton-Wellesley Hospital	Newton	MA	☐
Tufts - New England Medical Center Hospitals	Boston	MA	☐
~~zzz~~Beth Israel Deaconess Hospital	Boston	MA	☐
			☐

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

Average weekly hours involved in: a) inpatient care 5 hrs/wk Change to: _____ hrs/wk

b) outpatient care 16 hrs/wk Change to: _____ hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 01/01/07 To 12/31/07

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

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

enclosed

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.: 226218**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

	YES	NO
23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? If your answer is "Yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (See Renewal Instructions, page 10.)		[redacted]

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

Massachusetts Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.: 226218**

PART C

Check One: **PHYSICIAN PROFILE**

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Tferzandi Date: 11/30/2007

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

FORM PCA-O (OFFICE BASED SURGERY)

If you answered **"Yes"** to Question #13 on your Renewal Application you must complete this PCA-O form, and include it with your renewal application. Please refer to the Massachusetts Medical Society (MMS) Office Based Surgery Guidelines and Instruction Booklet when completing this form. The Office Based Surgery Guidelines have been endorsed by the Board and are available at the Board's website at www.massmedboard.org.

Please be advised that the Board will use the information on this form to evaluate office based surgery standards across the state of Massachusetts only. The Licensing staff will forward this form directly to the Patient Care Assessment (PCA) office where your license number and name will remain confidential and will not be used for disciplinary purposes.

1. Please indicate your Office Facility Classification under the MMS Office Based Surgery Guidelines:

☐ Level I Office ☐ Level II Office ☐ Level III Office

2. If you indicate that you are a Level II or Level III Office please complete the following:

a) Provide the name of the Organization that accredited your practice:

_____

b) Provide a brief description of the types of surgery performed in your office.

_____

_____

_____

c) Do you have the Training required and defined in the MMS Office Based Surgery Guidelines for the Level of office surgery that you are performing (Level II or Level III)? ☐ Yes ☐ No

d) Do you have written policies and procedures for Emergency Care and Transfer; Medical Record and Anesthesia Care documentation; Infection Control and Patients' Bill of Rights as required and defined in the MMS Office Based Surgery Guidelines? ☐ Yes ☐ No

e) Do you have written policies and procedures for compliance with applicable federal and state laws and regulations, and reporting adverse incidents to the Massachusetts Board of Registration in Medicine, as required and defined in the MMS Office Based Surgery Guidelines? ☐ Yes ☐ No

f) Do you have a written Performance Improvement Program as required and defined in the MMS Office Based Surgery Guidelines? ☐ Yes ☐ No

3. If you responded **"No"** to any of the questions noted above, please briefly explain your response.

_____

_____

_____

Signed:_____ **Date:**___/___/____

See frequently asked questions and description of Levels I, II and III on the attached instruction sheet.

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

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

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

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

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

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

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

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

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

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

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

Massachusetts
Board of Registration in Medicine
Physician Profile

226218

This Profile is not available for public release until 12/25/2007.

Tanaz R. Ferzandi, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status:	Active
License Issue Date:	06/27/2005
Accepting New Patients:	No
Accepts Medicaid:	No
Primary Work Setting:	Hospital
Business Address:	Boston Urogynecology ~~Assoc~~ Associates 725 Concord Ave Ste 3300 Cambridge, MA 02138
Phone:	(617) 354-5452
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospitals:	Mount Auburn Hospital(Admitting) Newton-Wellesley Hospital(Admitting) Tufts - New England Medical Center Hospitals(Admitting) ~~zzz~~Beth Israel Deaconess Hospital(Admitting)

II. Education & Training

Medical School:	The University of Kansas, School of Medicine
Graduation Date:	2001
Post Graduate Training:	Beth Israel Deaconess Medical Center - Resident - Obstetrics and Gynecology (6/17/2001 - 6/16/2005) Mount Auburn Hospital - Fellow - Urogynecology (7/1/2005)

III. Specialty

Area of Specialty: Obstetrics and Gynecology

Urogynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Obstetrics & Gynecology	Obstetrics and Gynecology	

V. Honors And Awards

2005 Professor Louis Burke Award for Excellence in Colposcopy.
2001 Coghill Award for Cell Biology.
1994 Student Resaerch Award in Cell Biology. → Research
~~1984 Valedictorian.~~
~~1984 National Honor Society~~.
1984 ~~Presidents Scholar~~ Award.

VI. Professional Publications

Thapsigargin Shifts the Calcium Set Point of Pathathyroid Cells to lower Extracellular Calcium Endocrine Journal 12/97.

08/27/08 SS 17

Fields, Ray (MED)

From: borimweb@capeweb1.meganet.net on behalf of Tanaz Ferzandi
[redacted]
Sent: Monday, August 18, 2008 2:22 PM
To: webmaster@massmedboard.org; WebMaster
Cc: Fields, Ray (MED)
Subject: www.massmedboard.org - Physician Address Change

Last_Name = Ferzandi

First_Name = Tanaz
---
email = [redacted]
---
fax_number = 617-636-8315

Board_Number = 226218

DOB = [redacted]

M_Address1 = [redacted]

M_City = [redacted]

M_State = [redacted]

M_Zip = [redacted]

M_Country = [redacted]

M_Phone = [redacted]

B_Address1 = Tufts Medical Center

B_Address2 = Dept of Ob/Gyn - Box 324

B_City = Boston

B_State = MA

B_Zip = 02111

B_Country = USA

B_Phone = 617-363-2382

H_Address1 = [redacted]

H_City = [redacted]

H_State = [redacted]

H_Zip = [redacted]

H_Country = [redacted]

H_Phone = [redacted]

10/23/09 82 68

Massachusetts
Board of Registration in Medicine
Physician Profile

226218

This Profile is not available for public release until 05/30/2009.

Tanaz R. Ferzandi, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status: Active

License Issue Date: 06/27/2005

Accepting New Patients: (No) Yes

Accepts Medicaid: (No) Yes

Primary Work Setting: Hospital

Business Address: Tufts Medical Center
800 Washington Street, Box ~~324~~ 212
Boston, MA 02111

Phone: (617) 636-5890

Translation Services Available: ~~None Reported~~ Yes

Insurance Plans Accepted: ~~None Reported~~ Yes → get list

BCBS
Medicaid
Medicare
Tufts
HPHC
NHP
U.S. Health Care
United HC
Cigna
Fallon
Network Health

Hospitals:
Beth Israel Deaconess Medical Center
Mount Auburn Hospital
~~Newton-Wellesley Hospital~~ delete
Tufts - New England Medical Center Hospitals

II. Education & Training

Medical School: The University of Kansas, School of Medicine

Graduation Date: 2001

Post Graduate Training: Beth Israel Deaconess Medical Center - Resident - Obstetrics and Gynecology (6/17/2001 - 6/16/2005)
Mount Auburn Hospital - Fellow - Urogynecology (7/1/2005 - 6/30/2008)

III. Specialty

Area of Specialty: ~~Obstetrics and Gynecology~~

Urogynecology and Pelvic Reconstructive Surgery

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Obstetrics & Gynecology	Obstetrics and Gynecology	

V. Honors And Awards

2005 Professor Louis Burke Award for Excellence in Colposcopy.
2001 Coghill Award for Cell Biology.
1994 Student Research Award in Cell Biology.

VI. Professional Publications

Thapsigargin Shifts the Calcium Set Point of Pathathyroid Cells to lower Extracellular Calcium Endocrine Journal 12/97.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.
When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.

This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.

Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Ferzandi has not made a payment on a malpractice claim in Massachusetts in the last ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:

The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Ferzandi has had no criminal convictions in the past ten years.

B. Hospital Discipline

This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Ferzandi has no record of hospital discipline in the past ten years.

C. Board Discipline

This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Ferzandi has not been disciplined by the Board in the past ten years.

Print Name: Tanaz R. Ferzandi License Number: 220218

LIST ONLY INFORMATION, CORRECTIONS OR ADDITIONAL CERTIFICATIONS THAT ARE NOT CURRENTLY ON YOUR PHYSICIAN PROFILE.

10/23/09 SC

POSTGRADUATE TRAINING: List only corrections or additional postgraduate training facilities that are not currently on your Physician Profile.

		From	To
Facility: ~~Mt. Auburn Hospital~~	Position: Fellow	/ /	/ /
City:	State:	Country:	
Facility:	Position:	/ /	/ /
City:	State:	Country:	
Facility:	Position:	/ /	/ /
City:	State:	Country:	
Facility:	Position:	/ /	/ /
City:	State:	Country:	

Board Certifications: Please list your Board Certification(s) -Only American Board of Medical Specialties Certification (ABMS) that are not currently on your Physician Profile.

I am ABMS Board certified in:

Specialty:	Date certified/recertified: / /
Specialty:	Date certified/recertified: / /
Specialty:	Date certified/recertified: / /
Specialty:	Date certified/recertified: / /

Honors & Awards: List honors and awards that are not currently listed on your Physician Profile. Include dates beside title of award or honor.

Title: Year:
Title: Year:
Title: Year:
Title: Year:

Professional Publications: Please list Publications that are currently not on your Profile.

I hereby Certify under the penalties of perjury that all of the information provided is true.

Signed: Date: 05-20-2009

FACSIMILE TRANSMITTAL SHEET

Division of Urogynecology and Pelvic Reconstructive Surgery
Department of Obstetrics and Gynecology
Tufts Medical Center, 800 Washington Street - Box 232, Boston, MA 02111
Tel: 617-636-5890 // Fax: 617-636-3258

Date: 06-08-09

To: BRM Company: _____

Fax # 781-876-8383 Phone #: 781-876-8200

RE Profile Changes.

From: Rhonda Graham (for Tanaz R. Ferzandi, M.D.)

Number of pages, including this cover sheet: 1

NOTES / COMMENTS:

____ Urgent X Please confirm receipt ____ Please Comment

Please note changes to profile

Thx.

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

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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

May 18, 2009

Tanaz R. Ferzandi, M.D.
[redacted]

Dear Doctor Ferzandi:

This letter forwards to you the most current information that the Physician Profiles Project has in your file. We will withhold your Profile from public release until the date indicated on the profile. If you find factual inaccuracies, please correct them directly on the Profile and return only the sections requiring changes expeditiously to the Board, ATTN: Profiles. Or fax the corrections to the Profiles Department at (781) 876-8382. If no changes are necessary, please do not return the Profile to us.

In our continuing effort to provide the most accurate and up-to-date information to the public, we have made several changes to the way your information is presented on the profile. Please review the following carefully.

1. We now display all Massachusetts Hospital affiliations you report to us on your renewal application.
2. The restriction of a maximum number of listed insurance plans has been lifted; we will now show all insurance plans you accept.
3. We will now list more than 6 training sites for post-graduate education, if you provide this information to us; please identify the location, dates, and nature of the training.
4. Please be aware that the sections for practice specialties and Board certifications have changed. We will now display every practice specialty you report in Section III. The Board Certifications are shown in a separate section IV; again, the previous restriction of 2 has been lifted. We also provide more detailed information regarding your certification, as collected on your renewal application. The certifying entity (ABMS or AOA) is clearly identified, along with the certifying Board. Each general certification is accompanied by the subspecialty, if you chose to provide us with this information.
5. The sections for "Honors and Awards" and "Professional Publications" have been renumbered to sections V and VI, respectively.
6. We may have done some minor editing to fit your information into our data fields.
7. If you do not have a business address, the law requires the Board to submit the next address of record, the mailing address, even if the mailing address is the same as your home address.

Thank you for your help, past and present, in keeping the data as correct and current as possible

Very truly yours,
Public Information Unit

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
Tufts Medical Center
800 Washington Street - Box 232
Boston
Massachusetts - 02111
United States of America
(617) 636-5890

3) **Email Address:** [redacted]

4) **Fax Number:** (617) 636-3258

5) **Specialties**
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

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
Mount Auburn Hospital	Cambridge
Tufts - New England Medical Center Hospitals	Boston

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2009	09/30/2010	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

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

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?** [redacted]

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

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

Commonwealth of Massachusetts

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Tufts Medical Center/Medical Staff Office

ADDRESS: 800 Washington Street, Box ~~836~~ 836

CITY: Boston STATE: MA ZIP: 02111

(TYPE OR PRINT)
PHYSICIAN'S NAME: Tanaz R. Ferzandi M.D.

BUSINESS ADDRESS: 800 WASHINGTON STREET- BOX 232

CITY: BOSTON STATE: MA ZIP: 02111

MASSACHUSETTS
LICENSE NUMBER: 226218

SIGNATURE OF PHYSICIAN: Ferzandi. Date Received: 11/12/2010

Signed under the penalties of perjury

Check #: 222

DATE: 10/20/10 Check Amount: $ 10-

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

Initials:

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address: [redacted]

Home Address:

Business Address: Tufts Medical Center
800 Washington Street - Box 232
Boston
Massachusetts - 02111
United States of America
(617) 636-5890

3) **Email Address:** [redacted]

4) **Fax Number:** (617) 636-3258

5) **Specialties**
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

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
Mount Auburn Hospital	Cambridge
Tufts - New England Medical Center Hospitals	Boston

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2011	09/30/2012	Claims made with tail coverage

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

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

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

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d) Are any Application of Issuance of Process pending against you?

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

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

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

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

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

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

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? [redacted]

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Compliance with Legal Responsibilities

Online profile:

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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.**

Attachment 4

Commonwealth of Massachusetts

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Tufts Medical Center/Medical Staff Office

ADDRESS: 800 Washington Street, Box 836

CITY: Boston STATE: MA ZIP: 02111

(TYPE OR PRINT)
PHYSICIAN'S NAME: Tanaz R. Ferzandi M.D.

BUSINESS ADDRESS: 800 Washington Street - Box 232

CITY: Boston STATE: MA ZIP: 02111

MASSACHUSETTS
LICENSE NUMBER: 226218

Date Received: 4/8/14

SIGNATURE OF
PHYSICIAN: Tanaz R. Ferzandi

Check #: 512

Signed under the penalties of perjury

Check Amount: $ 10.00

DATE: 01-20-2013

Initials: CH

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) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Tufts Medical Center/Medical Staff Office

ADDRESS: 800 Washington Street, Box 836

CITY: Boston STATE: MA ZIP: 02111

(TYPE OR PRINT)
PHYSICIAN'S NAME: Tanaz R. Ferzandi M.D.

BUSINESS ADDRESS: 800 Washington Street - Box 232

CITY: Boston STATE: MA ZIP: 02111

MASSACHUSETTS
LICENSE NUMBER: 226218

SIGNATURE OF
PHYSICIAN: Tanaz R. Ferzandi.
Signed under the penalties of perjury

DATE: 05/25/2012

Date Received: 6/21/12
Check #: 162
Check Amount: $ 10.00
Initials: CM

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: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

Tufts Medical Center
800 Washington Street - Box 232
Boston
Massachusetts - 02111
United States of America
(617) 636-5890

3) **Email Address** [redacted]

4) **Fax Number:** (617) 636-3258

5) **Specialties**
Female Pelvic Medicine and Reconstructive Surgery
Gynecology
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

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
Tufts - New England Medical Center Hospitals	Boston

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2015	09/30/2016	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?** [redacted]

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

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

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

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

Commonwealth of Massachusetts

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8200

WAIVER FOR RELEASE OF INFORMATION

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

(type or print clearly)

SEND LICENSE
VERIFICATION TO: Tufts Medical Center/Medical Staff Office

ADDRESS: 800 Washington Street, Box ~~836~~ 232

CITY: Boston STATE: MA ZIP: 02111

(TYPE OR PRINT)
PHYSICIAN'S NAME: Tauaz R. Ferzandi

BUSINESS ADDRESS: 800 Washington St Box 232

CITY: Boston STATE: MA ZIP: 02111

MASSACHUSETTS
LICENSE NUMBER: 226218

SIGNATURE OF
PHYSICIAN: Tferzand.

Signed under the penalties of perjury

DATE: 11-1-2015

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

Date Received: 12/28/15
Check #: 195
Check Amount: $ 10.00
Initials: RF

TANAZ R. FERZANDI, M.D., M.A.

[redacted]

PERSONAL

Telephone: [redacted]
Date of Birth:
E-mail:

EDUCATION & TRAINING

Obstetrics and Gynecology, Residency 2001 - 2005 (present)
Beth Israel Deaconess Medical Center/Harvard Medical School, Boston, Massachusetts
Doctor of Medicine
University of Kansas Medical Center, Kansas City, Kansas, May 2001
Master of Arts, Cell Biology
University of Kansas Medical Center, Kansas City, Kansas, May 1995
Bachelor of Arts, Biology
University of Kansas, Lawrence, Kansas, January 1989

RESEARCH & PUBLICATIONS

"VIN and VaIN: Conservative Management and Analysis." Colposcopy Clinic 1990-2000.
Beth Israel Deaconess, Boston, Massachusetts. In progress with Dr. Louis Burke.
"Thapsigargin shifts the Ca^{++} Set Point of Parathyroid Cells to Lower Extracellular [Ca]."
Endocrine Journal, December 1997.
"The Effect of Thapsigargin on the Secretion of Parathyroid Hormone from Parathyroid Glands."
Master's Thesis, 1995.
"The Effect of Thapsigargin on PTH Secretion." Abstract and Poster Presentation.
American Society of Cell Biology, New Orleans, LA, December 1993.
"PTH Secretion and Thapsigargin." Abstract and Poster Presentation.
Ninth International Meeting of Endocrinology, Nice, France, September 1992.

HONORS & SCHOLARSHIPS

Coghill Award for Cell Biology, 2001
Frank Dewitt Bennett Scholarship, 2000
RM Gouldner Medical Scholarship, 1999
Dr. Thornton L. Waylan Scholarship, 1999
Leslie Friend Dalton Foundation Scholarship, 1997
"Honorary Mention" Award, 22nd Annual Research Forum, Univ. of Kansas Medical Center, 1994
Research Travel Scholarship, University of Kansas Medical Center, 1993 and 1992
Valedictorian, Governor's Scholar, President's Scholar, Kansas Honor Student, 1984
National Honor Society, 1983

CONFERENCES

CREOG Leadership Conference, Chicago, Illinois, May 2004
Kansas City Gynecological Society Meeting, Kansas City, Missouri, May 2000.
Kansas Association of Family Practice, Kansas City, Missouri, 1998
22nd Annual Student Research Forum, University of Kansas Medical Center, 1994
Meeting of the American Society of Cell Biology, New Orleans, Louisiana, 1993
Ninth International Meeting of Endocrinology, Nice, France, 1992

TANAZ R. FERZANDI, M.D., M.A.
[redacted]

ACTIVITIES & ORGANIZATIONS

Chief Resident Council, Beth Israel Deaconess Medical Canter, 2004
QA Committee Member, Department of Ob/Gyn, Beth Israel Deaconess Medical Canter, 2005
Junior Fellow, American College of Obstetrics and Gynecology, 2001
Massachusetts Medical Society, 2001
Medical School:

- 2001 Graduation Committee
- Wahl Academic Society
- American Heart Association Screening Volunteer
- American Medical Association
- Rosedale Community Outreach Project Volunteer
- American Medical Students Association
- American Medical Women's Association
- Christmas in October Volunteer Projects
- Student Representative – Microbiology Curriculum
- Zoroastrian Association of Kansas

Undergraduate:

- Overland Park Medical Center Emergency Department Volunteer
- Ronald McDonald House Charities
- United Way of Lawrence
- University of Kansas Governing Student Council
- Zoroastrian Association of Kansas
- Alpha Delta Pi Sorority

WORK EXPERIENCE

Shook, Hardy & Bacon Law Firm, Kansas City, Missouri. Research Analyst, 1996-1997.
Wisap/Market-Tiers, Inc., Lenexa, Kansas. FDA Liaison, 1995-1996.
Worthington Biochemical, New Jersey. Research Assistant for Development of Hepatocyte Culture Kits, 1992-1994.
Shook, Hardy & Bacon Law Firm, Overland Park, Kansas. Part-time Legal assistant, 1987-1997.
Ahura, Inc., Kansas City, Missouri. Accounts assistant, 1989-1992.
Halls, Inc. Kansas City, Missouri. Retail sales, 1989-1990.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

Tufts Medical Center
800 Washington Street - Box 232
Boston
Massachusetts - 02111
United States of America
(617) 636-5890

3) **Email Address:** [redacted]

4) **Fax Number:** (617) 636-3258

5) **Specialties**
Female Pelvic Medicine and Recc
Gynecology
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

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
Tufts - New England Medical Center Hospitals	Boston

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2013	09/30/2014	Occurrence Policy

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

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

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

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

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

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

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

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

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

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

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

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? [redacted]

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

Tufts Medical Center
800 Washington Street - Box 232
Boston
Massachusetts - 02111
United States of America
(617) 636-5890

3) **Email Address:** [redacted]

4) **Fax Number:** (617) 636-3258

5) **Specialties**
Female Pelvic Medicine and Reconstructive Surgery
Gynecology
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
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7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

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
Tufts - New England Medical Center Hospitals	Boston

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2017	10/01/2018	Claims made with tail coverage

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

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

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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?
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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?

[redacted]

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Physician Name: Tanaz R Ferzandi, M.D. **License No.:** 226218

Compliance with Legal Responsibilities

Online profile:

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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.

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10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

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

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

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RF 10.00 341

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.) Attn: MA. Tonya Moriarty

SEND LICENSE VERIFICATION TO: MEDICAL BOARD OF CALIFORNIA

ADDRESS: 2005 EVERGREEN STREET, SUITE 1200

CITY: SACRAMENTO STATE: CA ZIP: 95815

PHYSICIAN'S NAME: TANAZ R. FERZANDI

BUSINESS ADDRESS: 800 WASHINGTON ST,

CITY: BOSTON STATE: MA ZIP: 02111

MASSACHUSETTS LICENSE NUMBER: 226218

SIGNATURE OF PHYSICIAN:

DATE: 5/19/2019

Signed under the penalties of perjury

RECEIVED
MAY 22 2019
Board of Registration in Medicine

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: Tanaz R Ferzandi, M.D. **License No.:** 226218

Current Status: Active **License Expiration Date:** 1/22/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

USC Keck School of Medicine
2020 Zonal Avenue, IRD 234
Los Angeles
California - 90033
United States of America
(323) 409-3416

3) **Email Address:** [redacted]

4) **Fax Number:**

5) **Specialties**
Female Pelvic Medicine and Reconstructive Surgery
Gynecology
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[redacted]		

8) **Other states where you are now licensed to practice**
California

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

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

WorkSite	Location
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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? [redacted]

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.

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15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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: Tanaz R Ferzandi, M.D. **License No.:** 226218

☒ **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.**