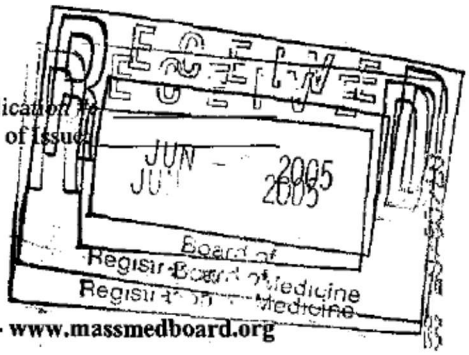
DA 618105 221

2260218 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: _____ Date: 11 / 26 / 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]
---

07/05/05 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

07/08/05 82 5

**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: [signature] 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: [signature] 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

Young Bin Kim
Signature of Certifying Physician

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

75710 License Number

MA 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: 4/28/08
(617) 667-4747 fax

Joi Leeth
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

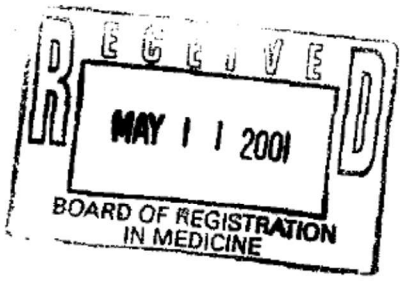
Print Name: TANAZ R. FERZANDI

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




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 to anticipated completion of training: 06/30/05
(Month) (Day) (Year) (Month) (Day) (Year)

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

Designated Official's Signature: _____ 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)