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APR 24 2014
Board of Registration in Medicine

Application #: 259942
For Board Use Only

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

INITIAL LIMITED LICENSE APPLICATION

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

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

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

SECTION A: Sworn Statement to be completed by applicant

1-A. Name: (Last) Singh (First) Anuja (MI) —

1-B. Other Name(s) —

YES NO

1) Since your graduation from medical school, have you ever been known under a different name or been licensed under a different name?

2) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?

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

2. Current Address: ______ Telephone Number: ______
City: ______ State: ______ Zip: ______

3. Date of Birth: ______ Place of Birth: ______
Month Day Year

E-mail Address ______

4. Sex: ☐ Male ☑ Female 5. U.S. Social Security Number: ______

6. Name of Massachusetts Training Program: BWH - OB/GYN Residency Program

75 Francis St. — Boston
Street Address — City

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

Date Received: 4 / 24 / 14

Check #: 500

Check Amount: $ 100.00

Initials: CM

PRINT NAME Anuja Singh

7. Name of premedical school(s): Columbia University
   Location: New York, NY, USA
   (City, State, Country)

8. Name of medical school(s): Stanford University School of Medicine
   Location: Stanford, CA, USA
   (City, State, Country)

   Date of Graduation: 06 / 15 / 14 (Month Day Year) Degree: ☑ M. D. ☐ D. O. Other (specify)_______

9. Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada? ☐ Yes ☑ No

   Name of Postgraduate Training Program ________________
   City: ________________ State: ________
   Training Dates: From: __/__/__ To: __/__/__ Specialty: ________

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

10. List states (abbreviations) where you ever had a license to practice medicine (include residency training licenses). Not Applicable
    ____ ☐ (Full) ____ ☐ (Full) ____ ☐ (Full) ____ ☐ (Limited) ____ ☐ (Limited)

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

    USMLE ☑ Step 1 ☑ Step 2 (CK) ☑ Step 2 (CS) ☐ Step 3
    NBME ☐ Part 1 ☐ Part II ☐ Part III ☐ COMLEX ☐ LMCC

YES NO

12-A. If you are a USMG, have you taken more than 4 years to complete medical school? (Include leave of absence for research, public service, M.D./Ph.D program, and personal reasons, etc.) (Contact your medical school to provide an explanation.)

12-B. If you are an IMG, have you taken more than 6 years to complete medical school? (Include leave of absence for research, public service, M.D./Ph.D. program and personal reasons, etc.) (Contact your medical school to provide an explanation.)

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

    If **you answered "yes"** to question #13,you must provide a timeline of all activities in chronological order, by month and year, from the date that you graduated from medical school to the present. The time line must be included in addition to your curriculum vitae. Explain any gaps in your professional activities since graduation from medical school. (See instructions.)

PRINT NAME Anuja Singh

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

This certifies that Anuja Singh (Name of Applicant) has been appointed

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the specialty of OB/Gyn as a PGY 1

Department: OB/Gyn Subspecialty: ______

at Brigham and Women's Hospital (Name of Healthcare Facility)

beginning 6 / 19 / 14 (Month Day Year) to anticipated completion of training: 6 / 30 / 18 (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: Laura Morrissey

Type or Print Name: Laura Morrissey

Official Title: TPL

Date: 4 / 15 / 14 Telephone Number: 857-307-0852

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

DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physician's Name: Anuja (First Name) ______ (Middle Initial) Singh (Last Name)

is applying for a limited license in Massachusetts. I received and opened the documents listed below that were sent to me by the physician in sealed envelopes or directly from the primary source:

- [x] Medical school verification form
- [x] Medical school transcripts
- [x] Letter from ~~program director~~ Registrar 5yr. program
- [ ] Evaluations
- [ ] Leave of absence
- [x] Other documents (describe): ERAS

I hereby certify under the penalties of perjury that I have not altered the attached documents and they are forwarded to the Board of Registration in Medicine, with the original envelopes attached, as received by me.

Designated Official: Lama Moriney Date: 4/15/14

Title: License Admin.

Name of Institution: Brigham and Women's Hospital

NOTE: Malpractice complaints, dismissals and other legal documents must be sent directly to the Board of Registration in Medicine from the primary source.

Affix institutional seal or if the institution does not have a seal, this form must be notarized.

Zip/Limitedrelease/2

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

Applicant's Signature: [signature] Date of Birth [redacted]

Print or Type Name: Singh (Last name) Anuja (First Name) — (Middle Initial) U.S. Social Security No: [redacted]

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

Name of Medical School: Stanford School of Medicine

Address: Registrar's Office, Medical School Office Bldg, 1265 Welch Rd. x341 City: Stanford State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Columbia University

Undergraduate School Address: NEW YORK, NY

(Continued on page 2)

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that SINGH ANUJA

(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* separately **for each academic year** in the section below):

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	09 /21 /09	08 /14 /10	09 /24 /12	08 /17 /13
	09 /20 /10	08 /13 /11	09 /23 /13	06 /11 /14
	09 /26 /11	06 /13 /12	/ /	/ /

The applicant attended 216 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one ☐ was awarded a degree in ____________ on (month/day/year) ___/___/___

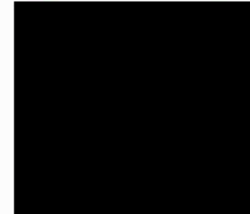
☒ will be awarded on 06 / 15 / 2014 **(Form B must also be completed and returned directly to the Board)**

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

YES **NO**

1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates or did the applicant take any leaves of absence, (i.e. for research, public service, participation in M.D./ Ph.D program) or for any "personal reasons?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

Verified DATE: 4/25 INITIALS: PM



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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Douglas Mónica

Print Name: DOUGLAS MÓNICA

Title: Registrar

Date: 04 /09 /14 Telephone: (650) 723-5085

E-mail address: drm@stanford.edu

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

PRINT NAME Anuja Singh

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

YES NO

14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training?

    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 or granted a leave of absence for research, personal reasons or any other reason by a medical school or a postgraduate training program? (provide a detailed explanation for the leave of absence for research, public service, participation in an M.D./Ph.D. program or for "personal reasons".) Contact your medical school or postgraduate training program to provide information. (See Initial Limited Instructions, page 4).

16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?

16-C. Have you ever, for any reason, been placed on probation in medical school or any postgraduate training program?

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

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?

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.)

YES NO

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 any medical staff membership, medical staff privileges or medical staff status?

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 or has such a suit been settled, adjudicated or otherwise resolved?

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?

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 function as a physician?

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

Applicant's Signature: [signature] Date: 4/3/14

Limited License

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Anuja Singh
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency, (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other documents, concerning my professional qualifications and competency, ethics, character, and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents and records be sent directly to:

Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
Website: www.mass.gov/massmedboard

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.

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

Applicant's Signature

4/3/14
Date of Signature

Singh, Anuja
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that ANUJA SINGH
(Student's Name)

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

from Stanford University S.O.M.
(Name of Medical School)

and will receive the degree on 06/15/2014.

Signature of Certifying Official: Douglas Mónica
(Original Signature is required – Stamps not accepted)

Printed Name: DOUGLAS MÓNICA

Title: Registrar

Date: 04/09/2014

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

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

Physician Name: Anuja Singh, M.D. **License No.:** 259942

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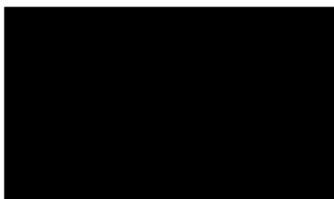
1. **Training Program**

   Current Training Program

   Facility: Brigham & Women's Hospital
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address: Brigham and Women's Hospital, Department of Obstetrics and Gynecology
   75 Francis St.
   Boston
   Massachusetts - 02115
   United States of America

   Home Address: 

3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 259942

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

   SECTION B: To be completed by the Program Director.

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

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

   Name: Laura Morrissey **Date:** 1/30/2015
   Designation: License Administrator **Telephone:** (857) 307-0852

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

This certifies that **Anuja Singh** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME:

Designated Official's Name: Laura Morrissey **Date:** 1/30/2015
Designated Official's Title: License Administrator **Telephone:** (857) 307-0852

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

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

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

Physician Name: Anuja Singh, M.D. **License No.:** 259942

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

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

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

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

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

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

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

Physician Name: Anuja Singh, M.D. **License No.:** 259942

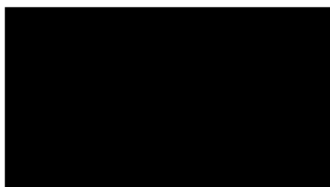
1. Training Program

Current Training Program

Facility: Brigham & Women's Hospital
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: Brigham and Women's Hospital, Department of Obstetrics and Gynecology
75 Francis St.
Boston
Massachusetts - 02115
United States of America

Home Address: 

3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 259942

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

SECTION B: To be completed by the Program Director.

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

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

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

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

This certifies that ______________________________ has been appointed as ______________

Department of ___________

Is the program accredited by the ACGME: ____

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

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

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

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

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

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

Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
2. I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
3. I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.
5. I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
6. I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
8. I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.
10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
11. Under the penalties of perjury, I declare that I have examined this limited renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for renewal of a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

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

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

Physician Name: Anuja Singh, M.D. **License No.:** 259942

1. **Training Program**

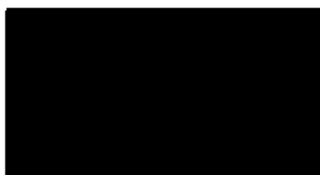
   Current Training Program

   Facility: Brigham & Women's Hospital
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address: Brigham and Women's Hospital, Department of Obstetrics and Gynecology
   75 Francis St.
   Boston
   Massachusetts - 02115
   United States of America

   Home Address:



3. **Email Address:**

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 259942

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

   SECTION B: To be completed by the Program Director.

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

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

   Name: Laura Morrissey **Date:** 1/26/2016
   Designation: License Administrator **Telephone:** (857) 307-0852

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

This certifies that **Anuja Singh** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME:

Designated Official's Name: Laura Morrissey **Date:** 1/26/2016
Designated Official's Title: License Administrator **Telephone:** (857) 307-0852

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?

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

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

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

RECEIVED
JAN 20 2017
Board of Registration in Medicine

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

WAIVER FOR RELEASE OF INFORMATION

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

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

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

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Anuja Singh

ADDRESS: 586 Washington St. Unit 2

CITY: Brookline STATE: MA ZIP: 02446

PHYSICIAN'S NAME: Anuja Singh

BUSINESS ADDRESS: 75 Francis St. C/O Yara Nunez A13-608A

CITY: Boston STATE: MA ZIP: 02115

MASSACHUSETTS LICENSE NUMBER: 259942

SIGNATURE OF PHYSICIAN: [signature]
Signed under the penalties of perjury

DATE: 1/17/17

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

Date Received: 1/20/17
Check #: 1098
Amount: $ 10.00
Initials: LS

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

Physician Name: Anuja Singh, M.D. **License No.:** 259942

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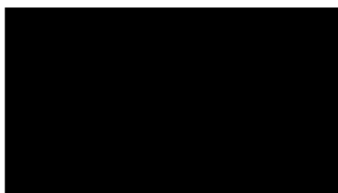
1. Training Program

Current Training Program

Facility: Brigham & Women's Hospital
Program: Obstetrics and Gynecology

2. Address & Contact Information

Mailing Address: Brigham and Women's Hospital, Department of Obstetrics and Gynecology
75 Francis St.
Boston
Massachusetts - 02115
United States of America

Home Address: 

3. Email Address:

4. Massachusetts Limited License
Your current Massachusetts Limited License Number is: 259942

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

SECTION B: To be completed by the Program Director.

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

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

Name:	Joanna Hazell	**Date:**	1/31/2017
Designation:	Manager, BWH Provider Services	**Telephone:**	(617) 582-1192

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

This certifies that **Anuja Singh** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name:	Joanna Hazell	**Date:**	1/31/2017
Designated Official's Title:	Manager, BWH Provider Services	**Telephone:**	(617) 582-1192

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

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

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---

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

Date Received: 6/23/20
Check #: 1080
Check Amount: $ 10.00
Initials: LS

RECEIVED
JUN 23 2020
Board of Registration in Medicine

Commonwealth of Massachusetts
Board of Registration in Medicine

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

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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:"**

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Minnesota Board of Medical Practice

ADDRESS: 2829 University Ave SE, Suite 500

CITY: Minneapolis STATE: MN ZIP: 55414-3246

PHYSICIAN'S NAME: Anuja Singh

~~BUSINESS~~ Home ADDRESS: [redacted]

CITY: [redacted] STATE: [redacted] ZIP: [redacted]

EMAIL ADDRESS: [redacted]

MASSACHUSETTS LICENSE NUMBER: 259942

SIGNATURE OF PHYSICIAN: [signature]
Signed under the penalties of perjury

DATE: [redacted]

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

Rev. 07/2019