90-Day Form

Dear Doctor,

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

Thank you.

Please select one of the boxes below:

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

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

My birthdate is [redacted]
Month Day Year

Signature: _____

Today's Date: 09 / 25 / 2015
Month Day Year

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

265386

RECEIVED
OCT 15 2015
Board of Registration in Medicine

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

FULL LICENSE APPLICATION

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

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

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

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

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

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

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

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

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

NPI (National Provider Identifier) Number: 1447593322

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

*Mailing Address: [redacted] Telephone: [redacted]
Number and Street

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

Home Address: [redacted] Telephone: [redacted]
Number and Street

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

Business Address: _____ Telephone: _____
Number and Street

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

E-mail Address: [redacted] Fax number: _____

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

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

Date Received: 10/15/15

Check #: 232

Check Amount: $ 600.00

Initials: WS

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

Name: University of Wisconsin Degree: BA, BS Year: 2003 Year: 2007
Street: _____ City: _____ State: _____

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

Medical School

Name: Harvard Medical School Degree: MD
Street: 25 Shattuck Street City: Boston State: MA

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

Medical School Graduation Date: 05 / 2013
Month Year

Postgraduate Education:

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

From **To**

Facility: Boston Medical School PGY Year: 3 6 / 2013 6 / 2016
Specialty: Family Medicine City: Boston State: MA

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

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

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

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

Examination History

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

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

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

Hospital Affiliations and Employment

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

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

1. List other states (abbreviations) where you are currently or have ever had a full license: _____ _____ _____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s):_____

4. List your practice specialt(ies): Family medicine (correction made 11/3/2015, KA)

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

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

7. Reason for requesting a Massachusetts medical license: desire to practice family medicine in massachusetts

8. Name of Facility: Boston medical center
   Address:_____ City:_____

9. Anticipated starting date in Massachusetts: 11 / 01 / 2015

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

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

Signature of Applicant

10 / 25 / 2015
Month Day Year

CERTIFICATE OF COMPLETION

AWARDED TO

Kirsten Austad

For completing the Middlesex District Attorney's Middlesex Children's Advocacy Center's 51A Mandated Reporter Training: Recognizing & Reporting Child Abuse, Neglect, and Exploitation.

On this 5 day of September, 2015

DISTRICT ATTORNEY
MIDDLESEX
MARIAN T. RYAN

MIDDLESEX
CHILDREN'S
ADVOCACY CENTER

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4605 F 617-638-4905
www.bu.edu/cme

BOSTON UNIVERSITY

Kirsten Austad, MD
[redacted]

Boston University School of Medicine

certifies that

Kirsten Austad, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: Internet Module 4

and is awarded **1.00** *AMA PRA Category 1 Credit(s)*™.

Date Completed: September 5th, 2015
Maximum Credits: 1.00
Total Credits Reported: 1.00

Score: 100

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *1.00 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for *1.00 hour of risk management study.*

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 1.00 hour of opioid education.

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4605 F 617-638-4905
www.bu.edu/cme

BOSTON UNIVERSITY

Kirsten Austad, MD
[redacted]

Boston University School of Medicine

certifies that

Kirsten Austad, MD

has participated in the enduring material titled:

Safe and Effective Opioid Prescribing for Chronic Pain: "Complex Conversations" Module

and is awarded **0.5** *AMA PRA Category 1 Credit(s)*™.

Date Completed: September 5th, 2015
Maximum Credits: 0.5
Total Credits Reported: 0.5

Score: 100

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *0.5 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for *0.5 hour of risk management study.*

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 0.5 hour of opioid education.

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4605 F 617-638-4905
www.bu.edu/cme

Kirsten Austad, MD
[redacted]

Boston University School of Medicine

certifies that

Kirsten Austad, MD

has participated in the enduring material titled

Safe and Effective Opioid Prescribing for Chronic Pain: "Using the PDMP" Module

and is awarded **0.25** *AMA PRA Category 1 Credit(s)*™.

Date Completed: September 5th, 2015
Maximum Credits: 0.25
Total Credits Reported: 0.25

Score: 100

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and the Massachusetts Board of Registration in Medicine. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of *0.25 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for *0.25 hour of risk management study.*

This program meets the criteria of the Massachusetts Board of Registration in Medicine for 0.25 hour of opioid education.

Barry M. Manuel, M.D.
Associate Dean

Boston University School of Medicine
The Barry M. Manuel Office of Continuing Medical Education

72 East Concord Street, A402
Boston, Massachusetts 02118
T 617-638-4605 F 617-638-4905 E cme@bu.edu
www.bu.edu/cme

BOSTON UNIVERSITY

Kirsten Austad, MD
[redacted]

Boston University School of Medicine

certifies that

Kirsten Austad, MD

has participated in the enduring material titled

"Prescribe to Prevent"

on September 5th, 2015
and is awarded 1.25 *AMA PRA Category 1 Credit(s)*™

Date Completed: September 5th, 2015
Maximum Credits: 1.25
Total credit reported: 1.25
Total credit claimed: 1.25

Score: 90

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this enduring material for a maximum of **1.25 AMA PRA Category 1 Credit(s)™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Accreditation Provider Number: 0000185

This program includes 1.25 credits which meet the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

This program includes 1.25 credits which meet the criteria of the Massachusetts Board of Registration in Medicine for opioid education.

Daniel P. Alford, MD, MPH, FACP, FASAM
Assistant Dean
Associate Professor of Medicine

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Kirsten Austad
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

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

Applicant's Signature

9/25/2015
Date of Signature

Austad, Kirsten E
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

Commonwealth of Massachusetts – Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

MEDICARE/TAX FORM

INSTRUCTIONS:

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

I, Kirsten Austad,
(type or print name)

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

SIGNED: _____ DATE: 9/26/2015

Social Security Number: [redacted]

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) 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.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: 9/25/2015

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

____ Participation in a Meaningful Use program as an eligible professional;
__X__ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: _____ DATE: 9/25/2015

Kirsten Elizabeth Austad, MD
[redacted]

Academic Training

8/2008 - 5/2013	**Harvard Medical School**, Boston, MA - MD
8/2003 - 5/2007	**University of Wisconsin-Madison,** Madison, WI, Medical Microbiology & Immunology and English literature – BS

Additional Training

6/2013 - 6/2016	Resident in Family Medicine, **Boston University**, Boston, MA

Employment

10/2010 – 6/2011	**Edmond J. Safra Center for Ethics** Harvard University Resident Fellow
4/2010 – 4/2013	**Brigham and Women's Hospital** Division of Pharmacoepidemiology and Pharmacoeconomics Researcher
6/2006 – 8/2006	**Wisconsin Department of Health and Family Services** Department of Nutrition and Physical Activity Area Health Education Center Summer Intern

Honors

5/2013	Harvard Medical School Presidential Scholars Public Service Initiative Award
5/2013	Massachusetts Medical Society Scholars Award Program
4/2009	Harvard Medical School International Community Service Grant
4/2006	F. Chandler Young Distinguished Senior Honors award, University of Wisconsin-Madison
4/2006	Highest Honors Award, Department of English, University of Wisconsin-Madison
3/2005	Barry Goldwater National Scholarship

Other Experience and Responsibilities

5/2014 – present	**Maya Health Alliance | Wuqu' Kawoq** Director of Women's Health
2/2010 – 2/2013	**American Medical Student Association** Member of PharmFree Steering Committee

7/2008 – 6/2011	**American Medical Student Association** Member of AIDS Advocacy Network Steering Committee
1/2008 – 7/2008	**CIEE Programs** Service learning volunteer in Santiago, Dominican Republic
8/2007 – 12/2007	**American Medical Student Association** Global AIDS intern
5/2007 – 8/2007	**SYTE volunteer program Ghana** Volunteer in regional hospital in Tamale, Ghana

Professional Societies

6/2013 - present	Massachusetts Medical Society resident member
6/2013 – present	American Academy of Family Physicians resident member

Publications

- Chary A, Flood D, Moore J, King N, **Austad K**, Martinez B, Garcia P, Dasgupta-Tsinkinas S, Rohloff P. Navigating Bureaucracy: Accompanying indigenous Maya patients with complex healthcare needs in Guatemala. Under review at Human Organization (submitted July 2015).
- Yeh JS, **Austad KE**, Franklin JM, Chimonas S, Campbell EG, Avorn J, Kesselheim AS. Association of medical students' reports of interactions with the pharmaceutical and medical device industries and medical school policies and characteristics: a cross-sectional study. PLoS Med. 2014 Oct;11(10): e1001743
- **Austad KE**, Avorn J, Franklin JM, Campbell EG, Kesselheim AS. Association of marketing interactions with medical trainees' knowledge about evidence-based prescribing: results from a national survey. JAMA Intern Med. 2014 Aug;174(8): 1283-90.
- **Austad KE**, Avorn J, Myers JA, Kowal MK, Campbell EG, and Kesselheim AK. Changing Interactions between physician trainees and the pharmaceutical industry: a national survey. J Gen Intern Med. 2013 Aug;28(8):1064-71
- Cosgrove L, Shaughnessy AF, Wheeler EE, **Austad KE**, Kirsch I, and Bursztajn HJ The American Physicatric Association's guideline for major depressive disorder: a commentary. Psychother Psychosom 2012 March;81(3): 186-8.
- **Austad K** and Kesselheim A. Conflict of Interest Disclosure in Early Education of Medical Students. *JAMA*. 2011 Sept 7;306(9): 991-2.
- **Austad K**, Avorn J, and Kesselheim A. Medical Students' Exposure to and Attitudes about the Pharmaceutical Industry: A Systematic Review. *PLoS Med* 2011 May;8(5): e1001037.
- Kesselheim A and **Austad K**. Residents: Workers or Students in the Eyes of the Law? *N Engl J Med.* 2011 Feb 24;364(8): 697-699.
- **Austad K**, Brendel R, and Brendel D. The Ethical Obligation of Medical School Professor in Relation to Conflicts of Interest. *Perspective in Biology and Medicine* 2010 Autumn;53(4): 534-544.
- **Austad K** and Oldfield B. Evaluation of Cell-Phone Based Clinical Decision-Making Algorithms in Rural Chiapas Mexico. Poster presented at Soma Weiss Research Day, Harvard Medical School, 2009.
- **Austad K**, Saluja S, Spencer S, Youkin S, and Corrado S. Urban Community Dental Health Outreach Program. Poster presented at International Conference on Urban Health, Baltimore, MD, 2007.

Languages

Fluent in medical Spanish and conversational in Kaqchikel (Mayan language)

Kirsten Austad

LIMITED LICENSE APPLICANT – FORM

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

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

Print or Type Name: Austad (Last name) Kirsten (First Name) E (Middle Initial) Social Security No: [redacted]

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

Name of Medical School: Harvard medical School

Address: 25 Shattuck St City: Boston State or Province: MA 02115

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? [X] Yes [ ] No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Wisconsin, Madison

Undergraduate School Address: _____

(Continued on page 2)

Kirsten Austad

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that Austad (Last name) Kirsten (First name) E (Middle initial)
(print the applicant's name):

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8 / 18 / 08	6 / 12 / 09	7 / 2 / 11	5 / 11 / 12
	8 / 17 / 09	6 / 27 / 10	6 / 25 / 12	5 / 17 / 13
	6 / 30 / 10	6 / 26 / 11	/ /	/ /

The applicant attended 180 total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year

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

☒ will be awarded on 5 / 30 / 13 **(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. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)	[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. Was the medical school education more than 4 years for U.S. graduates or more than 6 years for international graduates?		

COMMENTS: [redacted]

Seal Verified DATE: INITIALS:

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: Terese Galuszka

Print Name: Terese Galuszka

Title: Registrar

Date: 4 / 11 / 13 Telephone: (617) 432-1515

E-mail address: _____

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 sealed envelope. Thank you

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 Kirsten Austad
(Student's Name)

has completed the requirements for the [X] M.D. degree [ ] D.O. degree

from Harvard University
(Name of Medical School)

and will receive the degree on 5 / 30 / 2013.

Signature of Certifying Official: Terese Galuszka
(Original Signature is required – Stamps not accepted)

Printed Name: Terese Galuszka

Title: Registrar

Date: May 30, 2013 5/22/13

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

HARVARD MEDICAL SCHOOL

OFFICE OF THE REGISTRAR

25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115-6092
Telephone (617) 432-1515

July 24, 2015

Dear Sir/Madam:

I am pleased to confirm that Kirsten Elizabeth Austad, MD, attended Harvard Medical School from August 18, 2008 to May 30, 2013, and was awarded the MD degree by Harvard University on May 30, 2013.

If any additional information is required, please do not hesitate to contact the Registrar's Office.

Sincerely yours,

Terese Galuszka
Registrar

Seal Verified DATE: 10/16 INITIALS: MS

Sealed Envelope Initials: MS

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

I

d.

ic.

Signature of applicant

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

Signature of Notary

12/2/16
My commission expires

KATHRYN M. KRAEMER Notary Public Commonwealth of Massachusetts My Commission Expires December 2, 2016

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Kirsten Austad MD
(name of applicant)

for 2 1/2 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of Certifying Physician

46295 License Number

MA State

Thomas C. Hines, MD
Type or print name clearly

Address: 1 BMC Place
Dept of Family Medicine
City: Boston State: MA Zip: 02118
Telephone: (617) 414 4465
Date: 10/21/2015

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

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 9/25/2015

Print or Type Name: Kirsten Austad

Name of Institution: Boston medical center

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: Boston Medical Center

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

Enrollment and Participation: Our records indicate that Kirsten Austad (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

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
Residency	1	Family Medicine	06/24/2013	06/30/2014	Yes	ACGME
Residency	2	Family Medicine	7/1/2014	6/30/2015	Yes	ACGME
Residency	3	Family Medicine	7/1/2015	6/30/2016	No, expected	ACGME to complete 6/30/2016

(Continued on page 2)

APPLICANT'S NAME: Austad, Kirsten

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?		

Seal Verified 10/16
DATE:
INITIALS: MA

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

COMMENTS: [redacted]

AFFIX INSTITUTIONAL SEAL HERE

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

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

Program Director's Signature:

Print Name: Thomas C. Hines, MD

Academic Title: Residency Program Director, Dept of Family Medicine

Telephone: (617) 414-4465 Today's Date: 9/25/15

E-mail address: thomas.hines@bmc.org

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

PRINT NAME: Austad, Kirsten E DATE: 9/25/2015

FULL LICENSE APPLICATION SUPPLEMENT

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

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

PRINT NAME: Austad, Kirsten E DATE: 9/25/2015

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

PRINT NAME: Austad, Kirsten E DATE: 9/25/2015

CONFIDENTIAL INFORMATION

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

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

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

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

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

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

PRINT NAME: Austad, Kirsten E DATE: 9/25/2015

CERTIFICATIONS

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

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

Applicant's Signature:  Date: 9/25/2015

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

Current Status: Active **License Expiration Date:** 11/18/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
16 Lakeville Road Apt 8
Boston
Massachusetts - 02130
United States of America
(608) 209-1001

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

4) **Fax Number:**

5) **Specialties**
Family Medicine

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[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
Brigham & Women's Hospital	BWH Main

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 16 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2016	12/31/2016	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 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?

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

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?

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
Physician Renewal Application

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

Current Status: Active **License Expiration Date:** 11/18/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

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

4) **Fax Number:**

5) **Specialties**
Family Medicine
Hospitalist

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[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
Boston University Medical Ctr Hospital	Boston

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 16 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	07/01/2018	06/30/2019	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 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) MassHealth Enrollment Status
I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

☒ **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.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

Current Status: Active **License Expiration Date:** 11/18/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

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

4) **Fax Number:**

5) **Specialties**
Family Medicine
Hospitalist

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
[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
Boston University Medical Ctr Hospital	Boston

HealthQuarters Lawrence, MA

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 16 hrs/wk
b) outpatient care 8 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Ctr Ins.	06/30/2020	06/30/2021	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?
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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?** [redacted]

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.** No

Pursuant to Board Policy 2020-03, for the duration of this state of emergency and until December 31, 2020, the continuing medical education (CME) requirement for physicians is suspended.

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) Domestic Violence and Sexual Violence Training Requirement

Have you completed training and education on the issue of domestic violence and sexual violence? Yes

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

Physician Name: Kirsten E Austad, M.D. **License No.:** 265386

☒ **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.**

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: Rhode Island Board of Medical Licensure and Discipline

ADDRESS: 3 Capitol Hill Room 205

CITY: Providence STATE: RI ZIP: 02908-5097

PHYSICIAN'S NAME: Kirsten Austad

BUSINESS ADDRESS: 285 Fairmount Ave

CITY: Hyde Park STATE: MA ZIP: 02136

EMAIL ADDRESS: [redacted]

MASSACHUSETTS LICENSE NUMBER: 265386

SIGNATURE OF PHYSICIAN:

DATE: 10/5/2021

Signed under the penalties of perjury

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

Commonwealth of Massachusetts
Board of Registration in Medicine

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

PHYSICIAN LICENSE VERIFICATION REQUEST

INSTRUCTIONS

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

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

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

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

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

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

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

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

NOTICE TO THE APPLICANT

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

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