

PHYSICIAN TO APPEAR

EXAMINATION

ENDORSEMENT

MD18290  
LICENSE NUMBER

1/26/22  
ISSUE DATE

KIRSTEN AUSTAD  
PHYSICIANS NAME

APPLICATION RECEIVED 12/24/21  
DATE

FEE RECEIVED 12/24/21  
DATE

NATIONAL PRACTITIONER DATA BANK SELF-QUERY

FM  
SPECIALTY CODE

STATE LICENSURE VERIFIED MA

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FCVS APPLICATION

UA

=====

LICENSING COMMITTEE

CHIEF ADMINISTRATIVE OFFICER

\_\_\_\_\_  
JENNIFER BARRY

[Signature]  
JAMES MCDONALD MD

\_\_\_\_\_  
PATRICIA DELANEY

APPROVED 1/26/22  
DATE OF APPROVAL

\_\_\_\_\_  
SAJEEV HANDA MD

DENIED \_\_\_\_\_  
DATE OF DENIAL

\_\_\_\_\_  
JAMES MONTI MD

=====

EMAILED PHYSICIAN OF OUTSTANDING CREDENTIAL(S) \_\_\_\_\_

*Rec'd 1/12/22*

*Addendum 2 Es Incomplete*

*[Signature]*

*Rec'd 1/11/22*  
*Snel*  
*[Signature]*

CREATED BY AP

AUSTAD

PHYSICIANS NAME



\*\*\*FOR OFFICE USE ONLY\*\*\*

Receipt #

1652663

ID #

672089

Issue Date

License #

## Rhode Island Board of Medical Licensure and Discipline

Room 205  
3 Capitol Hill  
Providence, RI 02908-5097

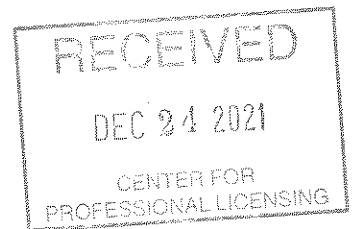
### Instructions and License Application for:

- Allopathic Medicine
- Osteopathic Medicine
- Academic Faculty  
(Limited Medical Registration)
- Temporary Post Graduate – Allopathic Medicine

PGY 2 \_\_\_\_\_ PGY 3 \_\_\_\_\_

- Temporary Post Graduate – Osteopathic Medicine

PGY 2 \_\_\_\_\_ PGY 3 \_\_\_\_\_



Kirsten E Austad

*Applicant – Print/Type Name (First/MI/Last)*

- I am also applying for a RI Uniform Controlled Substance Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855

TTY/TDD: (800) 745-5555

Fax: (401) 222-2158



I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Notary: Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.



*Kirsten Elizabeth Austad*

Applicant's Signature (must be signed in the presence of a notary)

Austad

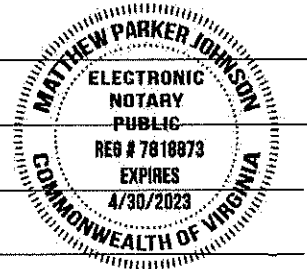
Applicant's Printed Last Name

Kirsten E.

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

10/14/2021

Date of Signature (must correspond to date of notarization)



State of Virginia, County of Fairfax

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 14 day of October, 2021.

Notary Public Signature: *Matthew Parker Johnson*

My Notary Commission Expires: April 30, 2023

Completed via Remote Online Notarization using 2way Audio/Video technology

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868-5000

**Rhode Island Board of Medical Licensure and Discipline**

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

**ADDENDUM 1  
Reciprocity Release Form**

Substitute forms are not acceptable. This form may be duplicated as needed.

**THIS SECTION TO BE COMPLETED BY THE APPLICANT**

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Kirsten Austad [Signature] 11/2/2021  
 Print/Type Full Name Signature Social Security Number Date  
 [Redacted] [Redacted]  
 Previous Names Used Social Security Number Date of Birth  
MA # 265386 9/20/2020  
 License Number Date Issued

**THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD**

Basis for issuing license:

NBME  NBOME  USMLE  LMCC  FLEX \_\_\_\_\_ State Sponsor  State Exam \_\_\_\_\_ (State)

If a combination of exams were taken, please list the specific combination: \_\_\_\_\_

*Please see  
MA Physician  
License Verification  
mailed from the  
BQM*

License Status:  Active  Inactive  Lapsed Original Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Questions:**

- 1. Has this physician ever been investigated by your Board?  Yes  No
- 2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- 3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- 4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank?  Yes  No
- 5. Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to any of the above questions, please provide a written explanation below, and attach a copy of all supporting documentation (e.g. Board order, complaint, etc.). Use a separate sheet if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

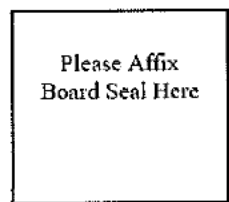
**Certification:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

Full Name and of Licensing Board including State \_\_\_\_\_



Please return directly to the Board at the above address. Thank you for your prompt cooperation.

**Rhode Island Board of Medical Licensure and Discipline**

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

**ADDENDUM 2  
Additional Physician Information**

Complete each section as instructed.

1. **Specialty of Practice:** Refer to the ABMS Certification Codes List (pages 4 and 5 of this addendum) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

FM  
Primary Specialty Code

Board Certified?  Yes  No  
If Yes, Year Certified/Recertified: 2018

Secondary Specialty Code

Board Certified?  Yes  No  
If Yes, Year Certified/Recertified: \_\_\_\_\_

Secondary Specialty Code

Board Certified?  Yes  No  
If Yes, Year Certified/Recertified: \_\_\_\_\_

Secondary Specialty Code

Board Certified?  Yes  No  
If Yes, Year Certified/Recertified: \_\_\_\_\_

2. **Practice Information:** Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia  
ADM = Administration  
FTY = Faculty  
FEL = Fellowship  
GRP = Group  
HSP = Hospital  
HMO = HMO  
OFC = Office  
RES = Research  
OTH = Other

Location #1: instED, LLC  
City: Boston MA 02108 Practice Type (See Code): OTH

Location #2: \_\_\_\_\_  
City: \_\_\_\_\_ Practice Type (See Code): \_\_\_\_\_

Location #3: \_\_\_\_\_  
City: \_\_\_\_\_ Practice Type (See Code): \_\_\_\_\_

Identify any translational services that may be available at your primary practice location: \_\_\_\_\_

3. **Medical School Faculty Appointments:** Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

Boston University School of medicine - resident supervising responsibilities

4. **Medical Licensure:** List all countries (other than the U.S. and Canada) in which you are now, or ever have been licensed to practice medicine, or any other profession.

Country \_\_\_\_\_  Active  Inactive  
Country \_\_\_\_\_  Active  Inactive  
Country \_\_\_\_\_  Active  Inactive

5. **Board Discipline:** List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet.

Check here if not applicable

Licensing Board (abbreviate) and Nature of Action: (e.g. TX - Professional Misconduct)	Month/Year	Type of Discipline:
	/	
	/	
	/	
	/	
	/	

6. **Hospital Discipline:** Please explain any disciplinary actions and attach any relevant supplemental materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.

Check here if not applicable

(1) Name of Hospital

Month / Day / Year Type of Action

(2) Name of Hospital

Month / Day / Year Type of Action

(3) Name of Hospital

Month / Day / Year Type of Action

(4) Name of Hospital

Month / Day / Year Type of Action

7. **Criminal Convictions:** Respond to the questions below, then list any criminal convictions(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending, including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your records)?  Yes  No

Abbreviation of State and Conviction\*

(e.g. CA - Illegal possession of a controlled substance)

Month/Year

	/
	/
	/
	/

\*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she pleads guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

Applicant Name: Kirsten Axtell  
Rhode Island Board of Medical Licensure and Discipline

Date: 1/19/2022  
Attachment 3, Page 3 of 3

8. **Questions:** Check either "Yes" or "No" for each question below. Note: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

- |  | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|
| 1. During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. During any Post Graduate Training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave)   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are there any charges or investigations pending, in any state, against you?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact us at (401) 222-3855 to discuss.           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

9. **Physician Honors and Peer-Reviewed Publications (Optional):** List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do not submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

Awards, Honors:

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Publications:

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10. **Professional and Community Memberships (Optional):** List any professional and community memberships. Do not submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

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Applicant Name: Kirsten Artad  
Rhode Island Board of Medical Licensure and Discipline

Date: 1/19/2022  
Addendum 3, Page 3 of 3

# ABMS Codes and Abbreviations

## Certification Codes

AMERICAN BOARD OF	GENERAL CERTIFICATE		SUBSPECIALTY CERTIFICATES	
Allergy and Immunology	A&I	Allergy and Immunology	CLI DLI	Clinical & Laboratory Immunology 5 Diagnostic Laboratory Immunology 5
Anesthesiology	Anes	Anesthesiology	CCM HPM PM	Critical Care Medicine Hospice and Palliative Medicine Pain Medicine 5
Colon and Rectal Surgery	CRS	Colon and Rectal Surgery	CLDI	Clinical and Laboratory Dermatological Immunology 4
Dermatology	D	Dermatology	DI  DP PedD	Dermatological Immunology/Diagnostic & Laboratory Immunology Dermatopathology Pediatric Dermatology
Emergency Medicine	EM	Emergency Medicine	HPM MT PEM SM UHM	Hospice and Palliative Medicine Medical Toxicology Pediatric Emergency Medicine Sports Medicine Undersea & Hyperbaric Medicine
Family Medicine	FM	Family Medicine	AM Ger HPM SLP SM	Adolescent Medicine Geriatric Medicine Hospice and Palliative Medicine Sleep Medicine Sports Medicine
Internal Medicine	IM	Internal Medicine	AI AM CCEP CCM CLI Cv DLI EDM En Ge Ger Hem HPM Inf IntvCd Nep Onc Pul Rhu SLP SM TH	Allergy and Immunology Adolescent Medicine Clinical Cardiac Electrophysiology 5 Critical Care Medicine Clinical & Laboratory Immunology 5 Cardiovascular Disease Diagnostic Laboratory Immunology 5 Endocrinology, Diabetes & Metabolism 5 Endocrinology & Metabolism 5 Gastroenterology Geriatric Medicine Hematology Hospice and Palliative Medicine Infectious Disease Interventional Cardiology Nephrology Medical Oncology Pulmonary Disease Rheumatology Sleep Medicine Sports Medicine Transplant Hepatology
Medical Genetics	MG CBCGn MG CBMG MG CCytG MG CGen MG CMGn MG PhDMG	Clinical Biochemical Genetics Clinical Biochemical/Molecular Genetics 4 Clinical Cytogenetics Clinical Genetics (MD) Clinical Molecular Genetics Ph D Medical Genetics 4	MBG MGP	Medical Biochemical Genetics Molecular Genetic Pathology
Neurological Surgery	NS	Neurological Surgery		
Nuclear Medicine	NuM	Nuclear Medicine		
Obstetrics & Gynecology	ObG	Obstetrics & Gynecology	CCM GO HPM MF RE	Critical Care Medicine Gynecologic Oncology Hospice and Palliative Medicine Maternal and Fetal Medicine Reproductive Endocrinology/Infertility
Ophthalmology	Oph	Ophthalmology		
Orthopaedic Surgery	OrS	Orthopaedic Surgery	HS OSM	Surgery of the Hand Orthopaedic Sports Medicine
Otolaryngology	Oto	Otolaryngology	ON PO PSHN SLP	Neurotology 5 Pediatric Otolaryngology Plastic Surgery within the Head and Neck Sleep Medicine
Pathology	Path AP Path AP/CP Path CP PathR	Anatomic Pathology Anatomic Pathology and Clinical Pathology Clinical Pathology Pathology Recertification	BB BBTM ChemP CytoP DP FPath Hem IP MGP MMB NPath PathF PChem PdP PHem PMG PMMB PPed RIP	Blood Banking 5 Blood Banking/Transfusion Medicine 5 Chemical Pathology 5 Cytopathology Dermatopathology Forensic Pathology 5 Hematology 5 Immunopathology 4 Molecular Genetic Pathology 5 Medical Microbiology 5 Neuropathology Pathology-Forensic 5 Pathology-Chemical 5 Pediatric Pathology 5 Pathology-Hematology 5 Pathology-Molecular Genetic 5 Pathology-Medical Microbiology 5 Pathology-Pediatric 5 Radioisotopic Pathology 4



# ABMS Codes and Abbreviations

## Certification Codes (continued)

AMERICAN BOARD OF		GENERAL CERTIFICATE	SUBSPECIALTY CERTIFICATES	
Pediatrics	Ped	Pediatrics	AI	Allergy and Immunology 4
			AM	Adolescent Medicine
			CCM	Pediatric Critical Care Medicine
			Cd	Pediatric Cardiology
			CAP	Child Abuse Pediatrics
			CLI	Clinical & Laboratory Immunology 5
			DBP	Developmental-Behavioral Pediatrics
			DLI	Diagnostic Laboratory Immunology 5
			HPM	Hospice and Palliative Medicine
			En	Pediatric Endocrinology
			Ge	Pediatric Gastroenterology
			HO	Pediatric Hematology-Oncology
			Inf	Pediatric Infectious Diseases
			MT	Medical Toxicology
			ND	Neurodevelopmental Disabilities
			Ne	Pediatric Nephrology
			NP	Neonatal-Perinatal Medicine
			PEM	Pediatric Emergency Medicine
			Pul	Pediatric Pulmonology
			Rhu	Pediatric Rheumatology
			SLP	Sleep Medicine
			SM	Sports Medicine
			TH	Pediatric Transplant Hepatology
Physical Medicine and Rehabilitation	PMR	Physical Medicine and Rehabilitation	HPM	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			PedRM	Pediatric Rehabilitation Medicine
			PM	Pain Medicine 5
			SCInj	Spinal Cord Injury Medicine
			SM	Sports Medicine
Plastic Surgery	PIS	Plastic Surgery	HS	Surgery of the Hand
			PSHN	Plastic Surgery within the Head and Neck
Preventive Medicine	PrM AeroM	Aerospace Medicine	MT	Medical Toxicology
	PrM GPM	General Preventive Medicine 5	UM	Undersea Medicine 5
	PrM OM	Occupational Medicine	UHM	Undersea & Hyperbaric Medicine 5
	PrM PH	Public Health 5		
	PrM PHGPM	Public Health and General Preventive Medicine 5		
Psychiatry and Neurology	ChiN	Neurology with Special Qualification in Child Neurology	AdP	Addiction Psychiatry
	N	Neurology	ChAP	Child and Adolescent Psychiatry 5
	Psyc	Psychiatry	ChiP	Child Psychiatry 5
			C/NPh	Clinical Neurophysiology
			FPsy	Forensic Psychiatry
			GPsyc	Geriatric Psychiatry
			HPM	Hospice and Palliative Medicine
			NeuroMed	Neuromuscular Medicine
			ND	Neurodevelopmental Disabilities
			PM	Pain Medicine 5
			PsycoMed	Psychosomatic Medicine
			SLP	Sleep Medicine
			VascN	Vascular Neurology
Radiology	Rad DR	Diagnostic Radiology	HPM	Hospice and Palliative Medicine
	Rad DRnt	Diagnostic Roentgenology 4	NR	Nuclear Radiology
	DRSCNR	Diagnostic Radiology with Special Competence in Nuclear Radiology 4	NRad	Neuroradiology
	Rad NM	Nuclear Medicine 4	PR	Pediatric Radiology
	Rad NM	Nuclear Medicine Medallion	VIR	Vascular and Interventional Radiology
	Rad R	Radiology 4		
	Rad Rnt	Roentgenology 4		
	Rad RO	Radiation Oncology 5		
	Rad ROR	Radiation Oncology Recertification		
	Rad RT	Radium Therapy 4		
	Rad TO	Therapeutic Roentgenology 4		
	Rad TR	Therapeutic Radiology 5		
Radiologic Physics	Rad DRMNP	Diagnostic & Medical Nuclear Physics 4		
	Rad DRMNP	Diagnostic Radiology & Medical Nuclear Physics		
	Rad DRP	Diagnostic Radiologic Physics		
	Rad MNP	Medical Nuclear Physics		
	Rad RP	Radiologic Physics 4		
	Rad RRP	Roentgen & Gamma Physics		
	Rad RRP	Roentgen Ray Physics		
	Rad TDRP	Therapeutic & Diagnostic Radiologic Physics 4		
	Rad TRNP	Therapeutic & Medical Nuclear Physics 4		
	Rad TRNP	Therapeutic Radiology & Medical Nuclear Physics		
	Rad TRP	Therapeutic Radiologic Physics		
	Rad XRP	X-Ray and Radium Physics 4		
Surgery	S	Surgery	HPM	Hospice and Palliative Medicine
	VascS	Vascular Surgery	HS	Surgery of the Hand
			PdS	Pediatric Surgery
			SCC	Surgical Critical Care
Thoracic Surgery	TS	Thoracic Surgery	CCS	Congenital Cardiac Surgery
Urology	U	Urology	PU	Pediatric Urology

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**Rhode Island Board of Medical Licensure and Discipline**

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

**ADDENDUM 3**

**Mandatory Addendum to Licensure Application  
Verification of Social Security Number  
Tax Payer Status Affidavit / Identity Verification**

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

**Licensee Declaration**

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # \_\_\_\_\_)
- I am in state receivership. (Case # \_\_\_\_\_)
- I have been discharged from bankruptcy. (Case # \_\_\_\_\_)

Medical doctor / physician

Type of Professional License for which you are applying

Kirsten Austad MD MPH

Full Name (Please Print or Type)

[Signature]

Signature

11/2/2021

Date

[Redacted] Social Security Number

[Redacted] Phone Number

This form must be completed, signed and attached to your license application for processing.

**Rhode Island Board of Medical Licensure and Discipline**

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

**ADDENDUM 5  
Voluntary Race/Ethnicity Questions**

This information is completely voluntary and will NOT affect your Application in any way.

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

**1. Ethnicity: Are you Hispanic or Latino? (Mark "No" if not Hispanic or Latino)**

No, not Hispanic or Latino       Yes, Hispanic or Latino

**2. Race: What is your race? (Mark one or more)**

American Indian or Alaska Native       Black or African American       White  
 Asian       Native Hawaiian or other Pacific Islander

For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

**1. Ethnic Categories:**

**Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

**Not Hispanic or Latino** – A person who is not Hispanic or Latino.

**2. Racial Categories:**

**American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

**Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Black or African American** – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

**Native Hawaiian or other Pacific Islanders** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

**White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

\* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.



# American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

October 4, 2021

To Whom It May Concern:

This letter verifies Kirsten Austad, M.D. (NPI: 1447593322) is currently certified with the American Board of Family Medicine (ABFM).

**Family Medicine Certification History:**

Jul 01, 2016 - \* Certification Number: 1004710079

\* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

**Family Medicine Certification Requirements:**

**Current Status:** \* Meeting Requirements

**Current Clinical Status:** Clinically Active

**Clinical Status History:**

Jun 28, 2018 - Clinically Active

Initial display of clinical status began June 2018 and history is only shown for certified periods.

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at [www.theabfm.org](http://www.theabfm.org).

Sincerely,

Mary McIntosh

Verification Coordinator and Candidate Assistant

# Uniform Application for Licensure

Application ID: 336233  
 FID: 215913062

License Requested: MD  
 License Type: Permanent Medical License  
 Submitted to: Rhode Island Board of Medical Licensure and Discipline  
 Submission Date: 10/4/2021 3:43 PM

## Practitioner Name

Austad, Kirsten

## Contact Information

### Address

Public Access	Board Contact	Type	Address
No	Yes	Home	[REDACTED]
Yes	No	Business	1 Boston Medical Center Place Massachusetts Boston, MA 02115 UNITED STATES

### Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
No	Yes	Business	(617) 638-8000	
Yes	No	Mobile	[REDACTED]	

### Email

Public Access	Board Contact	Email
No	Yes	[REDACTED]
Yes	No	kirsten.austad@bmc.org

## Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
52456456	[REDACTED]	[REDACTED]	[REDACTED] UNITED STATES	F	1447593322	MD	Yes

## Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Harvard Medical School	25 Shattuck Street Boston, MA 02115 UNITED STATES	08/01/2008	06/30/2013	06/30/2013	MD

## Fifth Pathway

None Reported

## ECFMG

Certificate Number	Issue Date
None Reported	

## Postgraduate Training

**Hospital Name:** Boston University Medical Center Program  
Boston, MA UNITED STATES

**Program Code:** ACGME 1202421644

### Attendance Dates:

**Institution:** Boston University Medical Center

**Start Date:** 06/30/2013

**Training Specialty:** Family Medicine

**End Date:** 06/30/2016

**Program Type:** Internship/Residency

**Training Status:** Completed

**Clinical %:** 100

**Administrative %:** 0

**Hospital Name:** Brigham and Women's Hospital  
Boston, MA UNITED STATES

**Program Code:**

### Attendance Dates:

**Institution:** Harvard Medical School

**Start Date:** 06/30/2016

**Training Specialty:** Global Women's Health

**End Date:** 06/30/2018

**Program Type:** Fellowship/Research

**Training Status:** Completed

**Clinical %:** 40

**Administrative %:** 60

## Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		04/14/2010	Pass	1
USMLE Step 2 CK Examination		06/09/2012	Pass	1
USMLE Step 2 CS Examination		11/08/2012	Pass	1
USMLE Step 3 Examination		08/11/2014	Pass	1

## State Licensure History

### MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Massachusetts Board of Registration in Medicine	MA	256465	06/03/2013	07/01/2016	Limited	Active
Massachusetts Board of Registration in Medicine	MA	265386	11/19/2015	11/18/2022	Full	Active

### Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

**Chronology of Activity Type**

<b>Practice/Emp/ Desc:</b>	<b>Harvard Medical School</b>	<b>Chronology Type:</b>	Medical Education
<b>Address:</b>	Boston, MA US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>		<b>From:</b>	08/01/2008 to 06/30/2013
<b>Clinical %:</b>			
<b>Admin %:</b>			
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	
<b>Practice/Emp/ Desc:</b>	<b>Boston University Medical Center Program</b>	<b>Chronology Type:</b>	Accredited Training
<b>Address:</b>	Boston, MA US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>		<b>From:</b>	06/30/2013 to 06/30/2016
<b>Clinical %:</b>	100		
<b>Admin %:</b>	0		
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	
<b>Practice/Emp/ Desc:</b>	<b>Brigham and Women's Hospital</b>	<b>Chronology Type:</b>	Other Training
<b>Address:</b>	Boston, MA US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>		<b>From:</b>	06/30/2016 to 06/30/2018
<b>Clinical %:</b>	40		
<b>Admin %:</b>	60		
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	
<b>Practice/Emp/ Desc:</b>	<b>Boston Medical Center</b>	<b>Chronology Type:</b>	Work
<b>Address:</b>	1 Boston Medical Center Place Boston, MA 02115 US	<b>Attendance Dates:</b>	
<b>Position/Dept:</b>	Assistant Professor - Family Medicine	<b>From:</b>	07/01/2018 to In Progress
<b>Clinical %:</b>	70		
<b>Admin %:</b>	30		
<b>Employment:</b>	<b>Staff Privileges:</b>	<b>Affiliation:</b>	

**Malpractice**

None Reported

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**PRACTITIONER PROFILE**

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Prepared for: Uniform Application for Physician State Licensure As of Date:10/4/2021

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**PRACTITIONER INFORMATION**

Name: Austad, Kirsten Elizabeth  
DOB: [REDACTED]  
Medical School: Harvard Medical School  
Boston, Massachusetts, UNITED STATES  
Year of Grad: 2013  
Degree Type: MD  
NPI: 1447593322

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**BOARD ACTIONS**

To date, there have been no actions reported to the FSMB

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**NATIONAL PROVIDER IDENTIFIER (NPI)**

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1447593322	Individual			06/04/2018

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**LICENSE HISTORY**

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
MASSACHUSETTS	256465	06/03/2013	07/01/2016	09/29/2021
MASSACHUSETTS	265386	11/19/2015	11/18/2022	09/29/2021

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**ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)**

DEA Number	Schedule	Address	Expiration Date	Last Reported
FA5709538	22N 33N 4 5	BOSTON,MA 02118	06/30/2024	09/07/2021



**PRACTITIONER PROFILE**

Prepared for: Uniform Application for Physician State Licensure As of Date:10/4/2021

Practitioner Name: Austad, Kirsten Elizabeth

**ABMS® CERTIFICATION HISTORY**

Certifying Board: American Board of Family Medicine  
 Certificate: Family Medicine  
 Certification Type: General  
 Certification Status: Certified  
 Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2016		02/15/2022	Initial	09/30/2021

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**AOA® CERTIFICATION HISTORY**

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.



## AUSTAD, KIRSTEN - SELF-QUERY RESPONSE

### A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: AUSTAD, KIRSTEN  
 Date of Birth: [REDACTED] Gender: FEMALE  
 Shipping Address: [REDACTED]  
 Social Security Number: [REDACTED] DEA: FA5709538  
 NPI: 1447593322  
 License: PHYSICIAN (MD), 265386, MA, GENERAL PRACTICE/FAMILY PRACTICE  
 Professional School(s): HARVARD MEDICAL SCHOOL (2013)

### B. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 11/02/2021

**The following report types have been searched:**

Medical Malpractice Payment Report	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are provided for restricted/limited use as prescribed by statutes listed on the preceding cover page.

----- No Reports Found Based on the Subject Information Submitted -----



NATIONAL PRACTITIONER DATA BANK

# NPDB



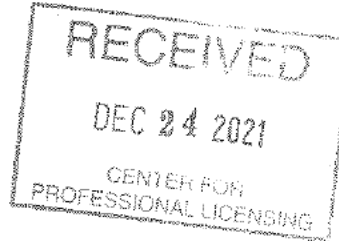
5500000182225264  
Process Date: 11/02/2021  
Page: 1 of 1

National Practitioner Data Bank  
U.S. Department of Health and Human Services  
P.O. Box 10832  
Chantilly, VA 20153-0832  
<https://www.npdb.hrsa.gov>

To: AUSTAD, KIRSTEN



From: National Practitioner Data Bank  
Re: Response to Your Self-Query



This self-query response is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

The response received from a self-query belongs to the subject of the self-query. Subjects may share the information contained in their own self-query responses with whomever they choose.

If you require additional assistance, visit the NPDB web site (<https://www.npdb.hrsa.gov>) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.

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## Licensee Information

Close Window

The Massachusetts Department of Public Health has implemented a deferral of expiration on all licenses, certifications, permits, and certificates of registration in good standing issued by the Board of Registration in Nursing, the Board of Registration of Physicians Assistants, the Board of Registration of Perfusionists and the Board of Respiratory Care in adherence to Order of the Commissioner of Public Health Covid 19 Order No. 2021-13 extending authorization for the issuance of temporary licenses for certain providers, and renewal or reactivation of certain temporary licenses (issued November 12, 2021).

### PLEASE NOTE WHEN REVIEWING THE EXPIRATION DATE:

- If the license expiration date is prior to March 10, 2020, the license is expired.
- Licenses in the professions of Nursing, Physician Assistants, Perfusionists, and Respiratory Care with an expiration date between March 10, 2020 and June 30, 2022, are current under the Commissioner's order, but will expire on June 30, 2022. If the expiration date is on or after June 30, 2022 for a license in one of these professions, the license is current and will expire on the stated date. MCSRs in these professions with a status of "Current COVID-19" will expire on June 30, 2022.

Please note, Emergency Medical Services certifications are not affected by the above guidance - their marked expiration date and status are accurate. See Emergency Medical Technicians (EMTs) and Paramedics for more information.

### Name

Full Name: Kirsten Elizabeth Austad

### License Information

License Number:	MA1025041A	License Type:	MCSR Physician
Profession:	MASS CONTROLLED SUBSTANCES	Date of Last Renewal:	10/25/2021
Issue Date:	12/9/2015	Expiration Date:	12/9/2024
License Status:	Current	Today's Date:	1/10/2022
Reciprocity State:			

### Specialty Information

### Address Information

City:	Boston
State:	MA
Zipcode:	02118
Country:	United States
Issue Date:	Expiration Date:

### Prerequisite Information

No Prerequisite Information

### Drug Schedule

Drug Schedule 1:	No	Drug Schedule 2:	Yes	Drug Schedule 3:	Yes
Drug Schedule 4:	Yes	Drug Schedule 5:	Yes	Drug Schedule 6:	Yes

### Disciplinary Information

**Important:** Disciplinary actions taken against a license will NOT display on any other license or associated permit or authorization. You must look up every license, permit, or authorization held by a licensee to see all disciplinary actions.

Case #	Date Closed	Discipline	Discipline Start	Discipline End
Currently there is no disciplinary information regarding this license.				

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