Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.
- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
  - **Return renewal application in GREEN envelope.**
  - **Enclose check with coupon in BLUE envelope.**

RECEIVED 04 BOARD OF REGISTRATION

Registration No.: 74421 Renewal Date: 06/15/1998

1. Activity Status: (Check only one) ☒ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Home Address:

CHERYL LYNN HAMLIN, M.D.
[redacted]

B) Business Address:
1493 CAMBRIDGE ST
CAMBRIDGE, MA 02139

Home Phone: [redacted]
Business Phone: (617)646-1043

4. A) Date of Birth: [redacted] C) Sex: F
B) Lic. Issue Date: 06/26/91 D) SS#: [redacted]

5. A) Name of Medical School:
University of Illinois College of Medicine
B) Year Graduated: 1988 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	60	Obstetrics and Gynecology

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts: [redacted]

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Corrections (type or print)

Other Name(s): _____

Mailing Address: [redacted]
City/Town: [redacted] State: _____
Zip: _____ Country: _____

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

Home: [redacted]
Business: (617) 498 1660

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____
Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree (MD/DO): _____

Code(s)	Hours Per Week in Mass.
___ ___ ___	~~30~~ 40
___ ___ ___	

If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts**

PRINT NAME AND NUMBER: Last Name: CHERYL LYNN HAMLIN Registration Number: 74421

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).

Facility Code: 108 /✓(AP) Facility Code: 71 /✓(AP) Facility Code: ___ /__(AP)
Facility Code: ___ /✓(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ___ b) Letter of Credit

Name of Insurer: Medical Professional Mutual Insurance Co.

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a)___ Not involved in direct/indirect patient care in Massachusetts b) ___ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 25

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 15 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 10 %

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	[redacted]	
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)?	☒	☐

☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature _____ Date: 4/30/98

PRINT NAME AND NUMBER: Last Name: CHERYL L. HAMLIN Registration Number: 74421

PART B CONFIDENTIAL MEDICAL INFORMATION

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space provided. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS	YES	NO
23. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?	[redacted]	
24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine?	[redacted]	

Treating Organization: _____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

- **Pursuant to G.L.c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62 C, § 49A, I hereby certify that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**

I hereby certify under the penalties of perjury that all the information on the Renewal Application and FORM R is true.

Signature _____ Date: 4/30/98

Massachusetts Board of Registration in Medicine
Physician Profile

CHERYL LYNN HAMLIN, MD

I did not receive this until 12/10/96

This Profile is not available for public release until 27 November 96

I. Physician Information

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

Dr. Hamlin has been in practice in Massachusetts: 5 years

Accepting new patients? Yes Accepts Medicaid? Yes

Primary work setting: Hospital

Business address: 22 Mill St Ste 204
Arlington, MA 02174-4738
Phone: 617-646-1043

1493 Cambridge St
Cambridge MA 02139

Translation services available: ~~None~~ Most Languages

Insurance Plans Accepted	Hospital Affiliations
No insurance plans reported	Mount Auburn Hospital Somerville Hospital

Cambridge Hospital
Somerville Hospital

II. Education & Training

Medical School: University of Illinois College of Medicine
Graduation Date: 1988

Post Graduate Training: 07/01/88 - 06/01/92 Boston City Hospital

III. Specialty

Obstetrics and Gynecology
Board Certified: Board of Obstetrics and Gynecology

IV. Honors and Awards

This physician has reported no awards.

V. Professional Publications

This physician has reported no publications.

VI. Malpractice Information

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

When considering malpractice data, please keep in mind:

* Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
* This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
74-1	ACTIVE	$250.00	06/12/94	$25.00

Mailing Address:

CHERYL LYNN HAMLIN, M.D.
[redacted]

Correction of Mailing Address:

Address (Mailing): [redacted]
City/Town:
State:
Country Code (See Table 1):

Directions: **Staple check to bottom of form. Add late fee if necessary.**

- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.
- Before proceeding, please read the instruction booklet. Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. JUN 02 1994
Pr.
Bk/B.E. 6/3/94

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. a) Address (Home):
[redacted]
b) Address (Business):
221 HARRISON AVENUE
BOSTON, MA 02118

3. Date of Birth: [redacted] Sex: F
Lic. Issue Date: 06/20/91 SS# [redacted]
Telephone Number:
Home [redacted] Business (617)624-5933

4. Name of Medical School:
University of Illinois College of Medicine
Year Graduated: [illegible] Degree: MD

5. a) Other states where you are now licensed to practice (Abbr):
b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.
[illegible]	[illegible] Obstetrics and Gynecology

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
Code: Code:
b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
Code: Code:

8. Drug License Number(s), if any: a) Federal (DEA)
b) State (MA)

Corrections of Pre-Printed Information

Name: Cheryl Hamlin
Address (Home): [redacted]
City/Town:
State: Zip:
Country Code: If 999 print Country:
Address (Business): 22 Mill Street #204
City/Town: Arlington, MA 02174
Country Code: If 999 print Country:

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:
Telephone Number:
Home: [redacted] Business: (617)646-1043

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code	Hours per Week in Mass.
	60

If OS, print specialty:

Code: Code:
Code: Code:
Federal (DEA): [redacted]
State (MA):

9. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested
You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions,for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Hamlin Registration Number: 74421

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: Controlled Risk Insurance Co, Grand Cayman

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am
(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___
(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 071 / ✓ (AP) Facility Code: 89 / ✓ (AP) Facility Code: ___ / ___ (AP)
Facility Code: ___ 1 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: 307 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes___ No X (Check one)

14. a) What is your principal work setting? (See Table 5) 15

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 20 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 24 hrs/wk in MA

Questions 15 through 23 refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		[redacted]
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

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

- **I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.**

- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: [signature] Date: 5/27/94

TUFTS ASSOCIATED HEALTH PLANS

The Managed Care Company

RELEASE FORM

In compliance with the Board of Registration in Medicine's (BORM) credentialing regulations, 243 CMR 3.00, TAHP and THP request that you sign the following release:

I hereby authorize:

A. My primary hospital to release to Tufts Associated Health Maintenance Organization, Inc.(TAHP) and Total Health Plan, Inc. (THP) any credentialing information in which I have an interest which may be requested by TAHP/THP; and

B. The Massachusetts Board of Registration in Medicine (BORM) to release to TAHP/THP my applications for initial or renewal registration when requested by TAHP/THP.

Cheryl Hamlin M.D.
PHYSICIAN'S NAME (please print)

74421
PHYSICIAN'S LICENSE #

PHYSICIAN'S SIGNATURE

DATE: 9/15/95

PRIMARY HOSPITAL AFFILIATION: St Auburn Hospital

Tufts Associated Health Plans, Inc.
333 Wyman Street
P.O. Box 9112
Waltham, Massachusetts 02254-9112
(617) 466-9400 Fax: (617) 466-8583

Tufts Associated Health Maintenance Organization, Inc.

Total Health Plan, Inc.
Preferred Provider Organization

ManagedComp, Inc.
Managed Care Workers' Compensation

CIGNA HealthCare

20 Speen Street
3rd Floor
Framingham, MA 01701
Telephone 1.800.345.9458

REQUEST FOR MEDICAL LICENSE/LICENSE RENEWAL FORM
(Please print legibly or type)

Name of Licensee: Cheryl L. Hamlin MD

Date of Birth: [redacted]

License Number: 74421

copy attached

I hereby authorize the Massachusetts Board of Registration in Medicine to make a photocopy of my most recent medical license application or renewal form, including all attachments and other explantory materials, and to send the photocopy to the following address:

CIGNA HealthCare of MA., Inc.

20 Speen Street

Framingham, MA 01701

Signed: [signature]

Date: 11/18/04

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1991-1993 Physician Registration Renewal Application

FILL

Registration No.	Status	Fee	Renewal Date
74421	ACTIVE	$150	06/15/92

Dr. CHERYL LYNN HAMLIN
[redacted]

For Office Use Only
M.R. ____ ___/___/___
Pr. ____ ___/___/___
ENTERED AT ____ ___/___/___
Ch. ____ ___/___/___
D.E. ____ ___/___/___

Directions:
- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:
I am applying to be registered with the following status: Active ✓ Inactive ____
I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information | **Corrections of Pre-Printed Information**

1. Other Name(s), if any, under which you were licensed:

Name: ____

2. a) Address (Home):
[redacted]

Address: ____
City/Town ____
State: ____ Zip: ____
Country Code: ____ (If 999 write Country): ____

2. b) Address (Business):

Address: 818 Harrison Ave
City/Town: Boston
State: MA Zip: 02118
Country Code: ____ (if 999, write Country): ____

3. Date of Birth: [redacted] Sex: F
Lic. Issue Date: 06/26/91 SSN #: [redacted]
Telephone Number:
Home: [redacted] Business: (617)324-8933

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): ____
Lic. Issue Date(M/D/Y): ___/___/___ SSN #: ____
Home: (___)____ Business: (___)____

4. Medical School Code: IL011 Year Graduated: 88 Degree: MD
Name of School:
University of Illinois College of Medicine

School Code: ____ Year Graduated: ____ Degree (MD/DO): ____
If 99999, write School: ____

5. a) Other States where you are now licensed to practice (*Abbr*):
b) States where you previously were licensed to practice (*Abbr*):

6. Specialty Code(s) (*See Table 3*):

Code	Hours per Week in Mass.
ⓐ	0
	0

Code	Hours per Week in Mass.
OBG	80

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) N 7.b) If YES, Enter Codes:
Code:
Code:

Code: ____
Code: ____

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) ____ b) How many DEA nos. do you have? ____
c) State (MA) #M ____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES X Waiver Requested ____
(You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See Instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*

30M - 9/90 - P813971

[For Office Use Only: Waiver Granted ____ Date: ___/___/___]

IN NAME AND NUMBER:
Physician Last Name: CHERYL L. HAMLIN Registration No.: 74421

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT_____. If applicable, check one.

List Insurer: BOSTON CITY HOSPITAL

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:
(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

(State how otherwise exempt):_____

11. Current Hospital Affiliations *(Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).*

Facility Code: 307 /__(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

Facility Code: ___ /__(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

If 999, write Name(s):_____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code:___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)
    a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes X No____ (Check one.)
    b) If you are in a MA program, are you a i) Resident X ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)
    c) How many hours per typical week do you spend in this MA post-graduate training program? 90 hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)
    a) How many hours per typical week are you currently involved in *outpatient* care in MA? 0 hrs./wk. in MA.
    b) How many hours per typical week are you currently involved in *inpatient* care in MA? 0 hrs./wk. in MA.

14. Principal Work Setting.
    a) What is your principal work setting? (*See Table 6*) 10

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A.
Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		[redacted]
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?		

Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.

I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.

Signature: [signature] Date 4, 11, 92

PLC

OK

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved:
Disapproved:

Application for Endorsement, Registration - NATIONAL BOARDS
(Fee-300.00must accompany APPLICATION - No currency.)

Filed: MAY 1 4 1991
By:
Form of Fee:

FOR OFFICE USE

Application # 6/26/91
Certificate # 74421 Date of Issue:

PLEASE TYPE OR PRINT SWORN STATEMENT

Name CHERYL LYNN HAMLIN
First Middle Last

Date of Birth [redacted]

Place of Birth [redacted]

Name on Birth Certificate CHERYL, Lynn HAMLIN

Mailing Address:* [redacted]

Address valid from (dates) 7/88 - present

Phone # DAY: [redacted]

Pre-medical Education

School University of ILLINOIS

Dates Attended 8/82 - 6/84

Medical Education

School University of ILLINOIS ILOII

Dates Attended 8/84 - 6/88

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

Place	Position	Dates
Boston City Hospital	intern/Resident	7/88 - present

List all states where you are or have been licensed: —

Are you a Diplomate of a Specialty Board? —
(name, if applicable)

REASON APPLYING FOR MASS. LICENSE: For Employment in MASS AFTER Residency

*NOTE: Change of address must be submitted IN WRITING to the Board of Registration in Medicine. Please include effective dates for new address upon submitting this information.

Batch # 302 By Date 5-24-91 FED. OK

016 11

POST GRADUATE EDUCATION AND HOSPITAL APPOINTMENTS:
Chronologically list all educational and professional training and experience from the date of graduation from medical school to the present. Account for all periods of time whether or not engaged in the practice of medicine.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
FULL LICENSE

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # ____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: CHERYL L. HAMLIN
PERMANENT ADDRESS: [redacted]
LOCAL MAILING: Same
ADDRESS IN (MA): Same

HOSPITAL: Boston City Hospital
ADDRESS: 818 HARRISON AVE
Boston, MA

Mailing address valid from:
(dates) 7/88 through present

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)	[redacted]	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?		
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?		
9 Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
12. Have you ever, for any reason, lost American Specialty Board Certification?		
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? ____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions.		

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #19 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Cheryl DATE: 12/29/90

University of Illinois
at Urbana-Champaign

Office of Admissions and Records

10 Henry Administration Building
506 South Wright Street
Urbana, IL 61801

February 7, 1991

TO WHOM IT MAY CONCERN:

This is to certify that Cheryl L. Hamlin (329-62-0375) attended the University of Illinois at Urbana-Champaign from August 30, 1982 to May 11, 1984 and was awarded the degree of Bachelor of Science in (LAS) General Biology from the College of Liberal Arts and Sciences on May 13, 1984. Cheryl last attended from August 23, 1984 to May 17, 1985 in the College of Medicine.

A certified document will have the University Seal embossed and the Registrar's signature in blue below.

FEB 7 1991

ASSOCIATE DIRECTOR FOR
RECORDS AND REGISTRATION

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

This section of the application must be completed by the Dean of your medical school. If you have attended more than one medical school, additional verification of medical instruction in the other school will be required.

Date: 2/10/91 19 91

I hereby certify that CHERYL L. HAMLIN has attended 4 years of instruction of not less than thirty-two weeks in each year in:

University of ILLINOIS - Rockford
(Name of medical school, location)

Exact dates of attendance of each year:

From:	Month:	9	Day:	17	Year:	84	To: Month:	5	Day:	17	Year: 85
From:	Month:	8	Day:	29	Year:	85	To: Month:	6	Day:	11	Year: 86
From:	Month:	6	Day:	23	Year:	86	To: Month:	6	Day:	12	Year: 87
From:	Month:	6	Day:	22	Year:	87	To: Month:	6	Day:	12	Year: 88
From:	Month:		Day:		Year:		To: Month:		Day:		Year:
From:	Month:		Day:		Year:		To: Month:		Day:		Year:

AND HAS RECEIVED THE DEGREE OF DOCTOR OF MEDICINE on June 12 19 88 from

University of Illinois College of Medicine - Rockford
(Name of medical school)

SCHOOL SEAL

X Alfred A. Lamanna Jr.
Signature of Dean

PHOTOGRAPH

photograph.
ure voucher
medical
done by a
n you are

Cheryl
signature of applicant

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

X Alfred A. Lamanna Jr.
signature of Dean or Notary

(expiration date of commission)

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

This certificate must be completed and signed by a physician legally authorized to practice medicine in the United States. The statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts.

Date: 4/26/91 19 91

This certifies that I have been personally acquainted with Cheryl Hamlin of Boston City for 3 years; that I believe her to be of good moral and professional character, and in every respect worthy of confidence. I recommend her to the Massachusetts Board of Registration in Medicine.

M. Abdel Hamid M.D.
(signature of certifying physician)

Address: [redacted]

License # 71811 State MA

AFFADAVIT OF APPLICANT:

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

Cheryl
Date: 5/9/91 19

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

617/727-3086

To all Applicants

Massachusetts General Laws Chapter 62C, section 49A, requires that you complete this statement to obtain licensure to practice a profession.

I, CHERYL L. HAMLIN,
Name

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

Date: 1/6/90

Signature

[redacted], Optional

Massachusetts General Laws Chapter 12, section 5, and 243 CMR 2.04(2)(k) require that you complete the following statement:

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

Date: 1/6/90

Signature

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
74421	ACTIVE	$250.00	06/15/96	$25.00

Mailing Address:
CHERYL LYNN HAMLIN, M.D.
[redacted]

Correction of Mailing Address

Address (Mailing): _____
_____
City/Town: _____
State: _____
Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- Add late fee if necessary.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.

For Office Use Only
M.R. _____
By _____
[redacted]

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. Business Address:
   22 MILL ST STE 204
   ARLINGTON, MA 02174-4738

3. Date of Birth: [redacted] Sex: F
   Lic. Issue Date: 06/26/91 SS#: [redacted]

   Home Phone [redacted] Business Phone (617)646-1043

4. Name of Medical School:
   University of Illinois College of Medicine
   Year Graduated: 88 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr):
   b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 1):

Code	Hours per Week in Mass.	
OBG	60	Obstetrics and Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: Code:

8. Drug license number(s), if any: a) Federal (DEA) [redacted]
   b) Massachusetts

Corrections of Pre-Printed Information

BOARD OF REGISTRATION IN MEDICINE

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

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____

Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	
___ ___ ___	

If OS, print specialty: _____

Code: OG Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE X INACTIVE ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Physician Last Name: Hamlin Registration Number: 74421

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 71 / ✓ (AP) Facility Code: 89 / ✓ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 1 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit ___ If applicable, check one.

List Insurer: CRICO

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___

State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No X (Check one)

13. a) What is your principal work setting? (See Table 4) 10

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 30 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 10 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 25% %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		[redacted]
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested ___

No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: 4/14/96

I. PHYSICIAN INFORMATION

CHERYL LYNN | | HAMLIN |
First Name | *Middle Initial* | *Last Name* | *Suffix*

Make changes to name here

Mass License # 74421
License Status Active

First Issue Date 06/26/91

22 Mill St. Ste 204
Arlington, MA 02174-4738
U.S.A.
(617) 646-1043

Hospital Affiliation

Mount Auburn Hospital
Somerville Hospital
Symmes Hospital

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☒ Yes ☐ No
Accept Medicaid? ☒ Yes ☐ No

II. EDUCATION & TRAINING

University of Illinois College of Medicine | MD | 88
Medical School | *Degree* | *Date*

Make corrections here

Boston City Hospital OB/GYN | 7/88 | End 6/92
Residency Program(s) | *Start* | *End*

Residency Program(s) | *Start* | *End*

Residency Program(s) | *Start*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: American College of OB/Gyn

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint .....

.....

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. HAMLIN

Date Case currently Pending - Amount Paid 0.0000 Basis for Complaint .....

Date ..... Amount Paid ..... Basis for Complaint .....

Date ..... Amount Paid ..... Basis for Complaint .....

Date ..... Amount Paid ..... Basis for Complaint .....

Date ..... Amount Paid ..... Basis for Complaint .....

Date ..... Amount Paid ..... Basis for Complaint .....

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Note: Please return the survey in the enclosed envelope to:

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
LIMITED LICENSE

FOR OFFICE USE ONLY
Limited License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.
NAME: CHERYL HAMLIN
PERMANENT ADDRESS: [redacted]

LOCAL MAILING ADDRESS IN (MA): _____

HOSPITAL: Boston City Hosp.
ADDRESS: 818 Harrison Ave
Boston MA 02118

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.		YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	[redacted]	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.		
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.		
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.		
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.		
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.		
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.		
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.		
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.		
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.		
11. Have you ever for any reason, lost American Specialty Board Certification?	11.		
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.		
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.		
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.		
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.		
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.		
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.		
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____, _____.	18.		

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00 within 60 days of commencement of hospital appointment in the Commonwealth of Massachusetts. To the best of my knowledge I meet the qualifications for Limited Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Cheryl Hamlin **DATE:** 4/7/88

(SEE REVERSE SIDE)

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

August 8, 1991

Dear Physician:

Please acknowledge receipt of this wall certificate by signing the statement below.

Sincerely yours,

Kate H. Graca

Kate H. Graca
Licensing Chief

I hereby acknowledge the receipt of an original wall certificate bearing my name, medical school, certificate number, and date of issue.

CHERYL HAMLIN
NAME (Please Print)

CHeNl
SIGNATURE

74421
License #

NAME Hamlin, Cheryl L.
Last First Middle/Other

[redacted]
Social Security Number

*SIGNATURE

1-31-91
Date of Request

SEND TO:

Cheryl Hamlin
[redacted]

NORTHERN ILLINOIS UNIVERSITY
Office of
Registration & Records
DeKalb, Illinois 60115

The following indicates item(s) completed by the university:

	YES	NO
1.	☐	☒
2.	☐	☒
3.	☐	☒
4.	☒	☐
5.	☐	☒
6.	☐	☒
7.	☐	☒
8.	☐	☒
9.	☐	☒

UNIVERSITY CERTIFICATION

1. Currently enrolled for the _____ Semester, 19 _____.
☐ Full Time ☐ Half Time ☐ Part Time

2. Was enrolled from _____ (month/year) to _____ (month/year).
☐ Full Time ☐ Half Time ☐ Part Time

3. Degree conferred _____ Date _____
Major _____ Minor _____

4. Other Cheryl L. Hamlin was enrolled at N.I.U. from 8-80 to 5-81 as a Biology Major.

5. Student Classification _____

*STUDENT AUTHORIZATION NEEDED FOR THE FOLLOWING ITEMS:

6. Total Hours Earned _____

7. Good Academic Standing With the University
☐ Yes ☐ No ☐ Confidential

8. Grade Point Average (on 4.00 system)
Preceding Term _____ ☐ Confidential
Cumulative _____

9. CLASS RANK _____ out of _____ PERCENTILE _____

A copy of this certification is maintained in the Office of Registration & Records.

Richard F. Durfee Jr.
Signature of Certifying Official
Director
Office of Registration and Records

1-31-91
Date

A $3.50 fee is charged per certification.

THIS INFORMATION IS BEING FORWARDED ON THE CONDITION THAT IT CANNOT BE RELEASED IN WHOLE OR PART TO ANY OTHER PARTY WITHOUT THE WRITTEN CONSENT OF INDIVIDUAL TO WHOM IT PERTAINS, IN ACCORDANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974.

R678-9/90

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

88-03031

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks) 2834

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.

FOR OFFICE USE
Date Received 6-13-88
Certificate #
By: Carol Form of Fee: CK

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: CHERYL (First) LYNN (Middle) HAMLIN (Last)
Date of Birth: [redacted]

Mailing Address [redacted]

Pre-medical School: University of Illinois Champaign
Medical School: University of Illinois - Rockford

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? NO
(give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?	1.	[redacted]
2.	Have you ever been denied a medical license?	2.	
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	
4.	Have you ever failed an examination before a State Medical Board?	4.	
5.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?	5.	
6.	Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff?	6.	
7.	Have you ever been a patient for the treatment of a mental illness?	7.	
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Cheryl Hamlin DATE: 4/6/88

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that Cheryl L. Hamlin has been appointed to the position of

PGY-1 in BOSTON CITY HOSPITAL
(Name of Hospital)

beginning July 1, 1988 and ending June 30, 1989.

Is the purpose of this application participation in a training program? YES (yes or no)
If yes, is this program ACGME or RRC accredited? YES (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? _____ (yes or no)

Maxine E. Kessler

Maxine E. Kessler, Administrative Director of Medical Affairs — 4/12/88
SIGNATURE — OFFICIAL CAPACITY — DATE

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

To be completed only if you attended college outside of the United States, Canada or Puerto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION
(to be completed ONLY by the Dean of the School)

Date _____ 19 ____

I hereby certify that _____ has creditably completed *two years* of a pre-medical course.

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

School Seal

_____
Dean

_____
School

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date April 8 19 88

I hereby certify that Cheryl L. Hamlin has creditably completed at least *three and one-half years* of medical education.

From 8 23 84 To 5 17 85
Month *Day* *Year* *Month* *Day* *Year*

From 8 29 85 To 6 11 86
Month *Day* *Year* *Month* *Day* *Year*

From 6 23 86 To 6 12 87
Month *Day* *Year* *Month* *Day* *Year*

From 6 22 87 To 6 12 88
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

and has received the degree of Doctor of Medicine on June 12 19 88

from Will University of Illinois College of Medicine
(name of Medical School)

School Seal

William H. Longwell M.D.
signature of Dean

If candidate has attended more than one medical school, additional verification of medical instruction is required.

89-1029-92

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Limited License Application, Page 1 of 2

L10035

Board Use Only:

Registration No.	Status	Fee	Date
		$25	

M.R. ____ ___/___/___
Pr. ____ ___/___/___
Bk. Canc 4/19/89
Ch. ____ ___/___/___
D.E. ____ ___/___/___
Fl. ____ ___/___/___

Important:
- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*–**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico X 2) Graduate of Foreign Medical School ___ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___.

This is a (check one) 1) New Application ___ 2) Renewal X If renewal, indicate current Limited License Number 9573 3) Change of Program ___

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

Applicants please circle one: I will be a PGY1 (PGY2) PGY3 PGY4 PGY5 PGY6 PGY7 Other (Specify): ___

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) HAMLIN (FIRST:) CHERYL (M.I.:) L

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation): NO

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: NO

2. a) Current Address (Mailing) (Valid Until 6/90): [redacted]

2. b) New Address (Mailing) (Valid After ___): Probably the same

2. c) Address (Work/Hospital): Boston City Hospital
816 HARRISON AVE.

2. d) Telephone (Work/Hospital): (617) 424-5166 Extension ___ 2. e) Telephone (Home): [redacted]

3. Date of Birth (MO/DA/YR): [redacted] 4. Sex: MALE ___ FEMALE F 5. Social Security No. (Optional) [redacted]

6. a) Medical School Name: UNIVERSITY OF ILLINOIS

6. b) Year Graduated: 1988 6. c) Degree: M.D. ✓ D.O. ___ Other (Specify) ___

6. d) Country: U.S. ✓ State IL Canada ___ Province ___ If Other *write* Name: ___

7. Specialty: OB/GYN

8. Name of Pre-medical School(s): UNIVERSITY OF ILLINOIS

Location: (City, State, Country) CHAMPAIGN, IL - Champaign County

9. Have you ever held a limited license in Massachusetts? Yes X No ___ If yes, list the license numbers you have held and name the institutions involved: Number of Massachusetts limited licenses: 1 Names of the institutions involved and the registration numbers: 9573

10. If you have had any one of the following, please circle which one and attach an explanation to this form: 1) A leave of absence from medical school 2) More than four years of medical school education. Question 10 applies to me: Yes ___ No X I have attached an explanation: Yes ___ No ___

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) ___ attached pages--is true.

Applicant's Signature: [signature] Date: 3/8/89

(See reverse side - You must complete Section C)

FORM 1/89

Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

SECTION B: To be completed and signed by the Designated Official of the Institution at which the Applicant has received an appointment.

This certifies that Cheryl Hamlin has been appointed to the position of PGY 2 in

(Specialty) Obstetrics & Gynecology at Boston City Hospital

beginning July 1989 and ending June 1990.

This program is accredited by the ACGME: Yes X No ___
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___ Anticipated completion date of training program: June 1992

Designated Official's Signature: Maxine E. Kessler (SM)

Type or Print Name and Title: Maxine E. Kessler, Adm. Director of Medical Affairs Date: 3/13/89

If renewal, I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes ___ No X

Signature of Designated Official

Type or Print Name and Title: Kenneth C. Edelin, Director Date: 3/13/89

****

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now licensed to practice (Abbreviate): NONE

12. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate): NONE

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes ___ No X I have attached an explanation: Yes ___ No ___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes ___ No X **If yes**, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes ___ No ___ Program Director's Certification has been requested: Yes ___ No ___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		[redacted]
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		[redacted]
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination, or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		[redacted]
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

****

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

√ Renewal ___ Change of Program

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

£12900

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

MAR 1990

M.R.		
Pr.		
Bk.		3/15/90
Ch.		
D.E.		
Fl.		

Important:

. *Read the accompanying instructions in their entirety before completing this form.*

. *Print legibly or type your answers.*

. *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**

Sign the application at the bottom of page two.

. **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) HAMLIN (FIRST:) CHERYL (M.I.:) L

2. Mailing Address: [redacted]

3. Name & Address of Training Hospital: BOSTON CITY HOSPITAL
818 HARRISON AVE, BOSTON MA

4. Current Limited License Number: 89-1029-92

5. **Change of Program Applicant:**

List previous license numbers, Training Institutions and Programs involved:

5a. Was previous training a prerequisite for entering into this program ____Yes ____No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: ____Yes ____No Program Director's Certification has been requested: ____Yes ____No.

6. **Renewal Applicant Only: To be completed by Program Director.**
I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes X No.

Type or Print Name and Title David Acker, M.D., Chief of Obstetrics/Gynecology

Signature of Program Director [signature] Date 3/8/90

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

This certifies that Cheryl Hamlin has been appointed to the position of Intern ____, Resident √.

Fellow ____ in Program Obstetrics/Gynecology (Program) at Boston City Hospital (Institution) beginning 7/1/90 and

Anticipated completion date of training 6/30/92.

This program is accredited by the ACGME: Yes √ No ____
If no, we have an ACGME approved training program in the applicant's specialty: Yes ____ No ____.

Designated Official's Signature: [signature]

Type or Print Name and Title: Maxine E. Kessler, Adm. Director of Medical Affairs Date 3/12/90

(Applicant See reverse side - You must complete Section C)

FORM 11/89

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): NONE

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		[redacted]
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: [signature] Date: 2-24-00

FORM 11/99

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

✓ Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

74421

RECEIVED APR 1991

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

Issue Date 4/22/91

APR 2 2 1991

M.R. ____ / / ____

Pr. ____ / / ____

Bk. ____ / / ____

Ch. ____ / / ____

D.E. ____ / / ____

Fl. ____ / / ____

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) HAMLIN (FIRST:) CHERYL (M.I.:) L
2. Mailing Address: [redacted]
3. Name & Address of Training Hospital: BOSTON CITY HOSPITAL 818 Harrison, Boston, MA
4. Medical School Name: UNIVERSITY OF ILLINOIS- Rockford
5. Current Limited License Number: 89-1029-92
6. **To be completed by Program Director:**

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes __x__No

Type or Print Name and Title Kwabena Kyei-Aboagye, M.D. Residency Program Director

Signature of Program Director [signature]

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

This certifies that Cheryl Hamlin has been appointed to the position of Intern ____, Resident __X__,

Fellow ____ in Program Obstetrics & Gynecology (Program) at Boston City Hospital (Institution) beginning 7/1/91 and

Anticipated completion date of training 6/30/92.

This program is accredited by the ACGME: Yes X **No** ____

If no, we have an ACGME approved training program in the applicant's specialty: Yes ____ **No** ____.

Designated Official's Signature: [signature]

Type or Print Name and Title: Maxine Kessler Adm. Dir., Med. Affairs Date 4/11/91

(Applicant See reverse side - You must complete Section C)

FORM 1/91

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): Ø

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		[redacted]
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best 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-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: [signature] Date: 9.18.91

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

This section of the application must be completed by the Dean of your medical school. If you have attended more than one medical school, additional verification of medical instruction in the other school will be required.

Date: 2/10/91 19 91

I hereby certify that CHERYL L. HAMLIN has attended 4 years of instruction of not less than thirty-two weeks in each year in:

University of ILLINOIS - Rockford
(Name of medical school, location)

Exact dates of attendance of each year:

From:	Month:	9	Day:	17	Year:	84	To: Month:	5	Day:	17	Year: 85
From:	Month:	8	Day:	29	Year:	85	To: Month:	6	Day:	11	Year: 86
From:	Month:	6	Day:	23	Year:	86	To: Month:	6	Day:	12	Year: 87
From:	Month:	6	Day:	22	Year:	87	To: Month:	6	Day:	12	Year: 88
From:	Month:		Day:		Year:		To: Month:		Day:		Year:
From:	Month:		Day:		Year:		To: Month:		Day:		Year:

AND HAS RECEIVED THE DEGREE OF DOCTOR OF MEDICINE on June 12 19 88 from

University of Illinois College of Medicine - Rockford
(Name of medical school)

SCHOOL SEAL

x Alfred G. Lamonte, Jr.
Signature of Dean

PHOTOGRAPH

photograph.
ure voucher
medical
done by a
n you are

Cheryl
signature of applicant

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

x Alfred G. Lamonte, Jr.
signature of Dean or Notary

(expiration date of commission)

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

This certificate must be completed and signed by a physician legally authorized to practice medicine in the United States. The statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts.

Date: 4/26/91 19 91

This certifies that I have been personally acquainted with Cheryl Hamlin of Boston City for 3 years; that I believe her to be of good moral and professional character, and in every respect worthy of confidence. I recommend her to the Massachusetts Board of Registration in Medicine.

M. Abd [illegible] M.D.
(signature of certifying physician)

Address: [redacted]

License # 71811 State MA

AFFADAVIT OF APPLICANT:

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

Cheryl Date: 5/9/91 19

Commonwealth of Massachusetts Board of Registration in Medicine
Two West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

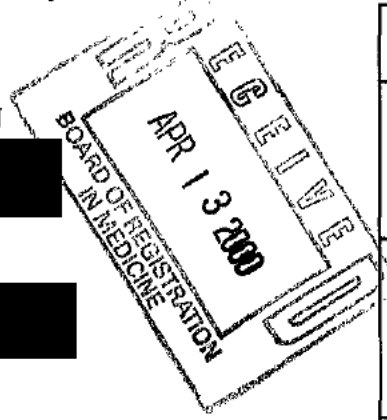
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope**

Registration No.: 74421 Renewal Date: 06/15/2000 1. Current Status: Active

If you want to change your current status, please indicate below: (Check one).

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see below *) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:



3. A) Mailing/Business Address:
CHERYL LYNN HAMLIN
[redacted]

B) Home Address:
[redacted]

Home Phone: [redacted]
Business Phone: 617

4. A) Date of Birth: [redacted] Sex: F
B) SS#:

5. A) Name of Medical School:
University of Illinois College of Medicine

B) Year Graduated: 1988 C) Degree: M.D.

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology
	0	

Please make corrections (type or print)

Other Name(s): _____

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

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

Home: (___) _____
Business: (617) 665-1660

Date of Birth: (M/D/Y): __/__/__ Sex: ☐ M ☐ F
SS#: __ __ __ - __ __ - __ __ __ __

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

Code: _____ Code: _____

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts: [redacted]

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.

PRINT NAME AND NUMBER: Last Name: HAMLIN Registration Number: 74421

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 532V (AP) 100 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%

Facility Code: ___/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%

If 999, print name(s): _____

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: Crico Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 10

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		[redacted]
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 4/21/00

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

PRINT NAME AND NUMBER: Last Name: Hamlin Registration Number: 74421

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS: YES NO

23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses. [redacted]

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

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.

Signature: [signature] Date: 4/11/00

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

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

Physician Registration Renewal Application

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *at least 4 weeks* before your renewal date.

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 74421 Renewal Date: 06/15/2004

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

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

A) Mailing/Business Address:

3. CHERYL LYNN HAMLIN
[redacted]

B) Home Address:
[redacted]

MAR 15 2004

Home Phone: [redacted]

Business Phone:

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (617) 665-2800

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

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

4. a) Date of Birth: [redacted] b) Sex: F
c) SS#: [redacted]

5. a) Name of Medical School: University of Illinois College of Medicine
b) Year Graduated: 1988 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology
	0	

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

8. Drug License Numbers, if
a) Federal (DEA): [redacted]
b) Massachusetts:

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

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

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

Facility Code: 532/✓ (AP) 100 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: ___/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Hamlin LICENSE NUMBER: 74421

11. My medical malpractice insurance is covered by ☑ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): CRICO Policy dates: From: 01/01/04 To: 12/31/04

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 25 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).
    1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 20 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care? 15 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. CLAIMS MADE (New or Pending): Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		[redacted]
15. CLAIMS (Resolved): Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: _____ Date: 3/12/04

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

PRINT NAME AND NUMBER: Last Name: Hamlin License Number: 74421

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the period since you signed your last renewal application. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS:	YES	NO
23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.		[redacted]
24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.		[redacted]

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

I hereby certify under the penalties of perjury that all the information on this Renewal Application, Part B and Form R is true.

Signature: _____ Date: 3/12/04

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin **License No.:** 74421

PART A

1) Current Status: Active **Renewal Due Date:** 05/18/2006 **Birth Date:** [redacted]

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

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

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

2a) MAILING ADDRESS

[redacted]

RECEIVED
MAR 16 2006
Board of Registration In Medicine

☐ *Check here to change this address*

2b) HOME ADDRESS

[redacted]

Phone: [redacted]

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

1493 Cambridge Street
Cambridge, MA 02139

Phone: (617)665-1660

☐ *Check here to change this address*

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: [redacted]

4) Fax Number: _____

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin **License No.: 74421**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts: [redacted]	___ ___ ___ ___ ___ ___ ___ ___
b) Federal (DEA): [redacted]	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	___ ___ ___ ___ ___ ___ ___ ___

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

Principal Work Setting: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 20

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

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Cambridge Public Hlth Commission (The)	☐	Admitting		40
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: _____ hrs/wk

b) outpatient care 20 hrs/wk Change to: _____ hrs/wk

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

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

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/01/06 To 12/31/06
(required)

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin **License No.: 74421**

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

YES **NO**

23) Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (see Renewal Instructions, page 9.) [redacted]

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

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

Signature: _____ Date: 3/8/06

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin . **License No.: 74421**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 3/9/06

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin **License No.: 74421**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

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

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

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

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

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

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐

☒ I have personally applied for an NPI.

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

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

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 6 0 0 X	OB/GYN
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	
Provider Taxonomy:	☐☐☐☐☐☐☐☐☐☐	

NPI REQUIRED INFORMATION

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

Social Security Number: [redacted]

State of Birth (if US): [redacted] Country of Birth (if outside the US): [redacted]

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature: _____ Date: 3/14/06

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

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required.

1. Current Status: Active Registration No.74421 Renewal Date: 06/15/2002

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

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
CHERYL LYNN HAMLIN
[redacted]

B) Home Address:
[redacted]

Home Phone: [redacted]

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

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

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

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: [redacted] b) Sex: F
c) SS#:

5. a) Name of Medical School:
University of Illinois College of Medicine
b) Year Graduated: 1988 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass. 40
OBG 0 0 Obstetrics and Gynecology

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts: [redacted]

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

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

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 532V (AP) 100 % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %
Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: HAMLIN LICENSE NUMBER: 74421

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Orico Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☒ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: (I am temporarily not employed until Sept 2002.
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No
13. A. What is your principal work setting? (See Table 4) 25
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 30 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		[redacted]
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: [signature] Date: 6/12/02

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

PRINT NAME AND NUMBER: Last Name: Hamlin Registration Number: 74421

CONFIDENTIAL MEDICAL INFORMATION

PART B

Questions 23 and 24 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details for all YES answers in space below. Before completing the following questions, refer to the instruction booklet for definitions and additional information.

IN THE PAST TWO (2) YEARS:

	YES	NO
23. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is "yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses.		[redacted]
24. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of the treatment, including dates and diagnoses.		[redacted]

YOU MUST SIGN AND INCLUDE PART B WITH YOUR RENEWAL APPLICATION

I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.

Signature: _____ Date: 6/12/02

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

Commonwealth of Massachusetts
BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Boston, MA 02118 – (617) 654-9810 www.massmedboard.org

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LOST, STOLEN OR MISPLACED WALLET SIZED CARD

Please submit the following:

- A personal check or money order for $18.00, made payable to the Commonwealth of Massachusetts.
- An explanation for the loss of your wallet card and signature on the statement below.

Please explain the loss of your wallet card: It is probably in my home but I can't find it.

I have made every reasonable attempt to locate my wallet card to no avail. I declare under the pains and penalties of perjury that my statements are true and correct.

Signature _____ Date 10/9/06

PRINT NAME: CHERYL HAMLIN LICENSE #: 74421

MAILING ADDRESS: [redacted]

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

Please forward the completed form with your check for $18.00 to the Board of Registration in Medicine at the above listed address. Thank you.

For Office use only

Date Received: 10/12/06 Date Completed: 10/17/06

Completed by: _____

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.: 74421**

04/23/08 09:12:26 93

PART A

1) **Current Status:** Active **Renewal Due Date:** 05/18/2008 **Birth Date:** [redacted]

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

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

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

2a) MAILING ADDRESS

[redacted]

☐ *Check here to change this address*

RECEIVED
APR 18 2008
Board of Registration in Medicine

2b) HOME ADDRESS

[redacted]

Phone: [redacted]

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

1493 Cambridge Street
Cambridge, MA 02139

Phone: (617)665-1660

☒ *Check here to change this address*

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

Business Address: 330 MT Auburn St
City/Town: Cambridge State: MA
Zip: 02139 Country: U.S.
Business Telephone: (617) 499-5161

Business address cannot be a Post Office Box

3) E-mail Address: [redacted]

4) Fax Number: _____

Correct your E-mail and Fax Number below:

[redacted]

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.: 74421**

(See Renewal Instructions, page 4.)

7) Drug License Numbers

a) Massachusetts: [redacted]

b) Federal (DEA) [redacted]

c) Federal (DEA) XS:

Corrections:

Please make corrections as necessary

8) Other states where you are now licensed to practice

9) States where you were previously licensed

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Cambridge Public Hlth Commission (The)			☐
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: _____ hrs/wk

b) outpatient care 20 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: currently being renewed @ MT Auburn Hospital

Policy dates: From ___/___/___ To ___/___/___

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

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

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

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

Check one:

☒ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.: 74421**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

CONFIDENTIAL MEDICAL INFORMATION

PART B

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

YES NO

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine? If your answer is "Yes," set forth the specifics of your condition and any related treatment, including dates and diagnoses (See Renewal Instructions, page 10.)

[redacted]

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

[redacted]

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.: 74421**

PART C

Check One: **PHYSICIAN PROFILE**

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 4/16/08

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

Massachusetts Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.: 74421**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

☐ My current NPI is: 1 4 7 7 5 2 2 6 8 6
☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	OB/GYN
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number: [redacted]
State of Birth (if US): [redacted] Country of Birth (if outside the US): _____
Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 4/18/08

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
None Reported

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

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

WorkSite	Location
Mount Auburn Hospital	

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/02/2010	12/31/2010	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

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 physical 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: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
None Reported

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

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

WorkSite	Location
Mount Auburn Hospital	

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/01/2012	12/31/2012	Claims made with tail coverage

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

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

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

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

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

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, 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 CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes

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

[redacted]

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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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.**

74421

WOMEN'S HEALTHCARE AT WALTHAM
781-893-5550

Re License application

Date 7/24/14

Attention Bettina Courts
781-876-8383

Please fax me my most recent application License 74421

to Fax
781.893.0448

WOMENS HEALTHCARE AT WALTHAM
355 WAVERLEY OAKS ROAD, SUITE #275
WALTHAM, MASS 02452
TEL# 781-893-5550/FAX# 781-893-0448

Cheryl Hamlin, MD
Arlene Pressman, NP

Julia Dickinson, CNM
Mary Culliton, CNM
Amanda Breed, CNM

DATE: 7-24-14

TO: Bertina County

FAX#:

FROM: Dr. Cheryl Hamlin

Number of Pages (including cover sheet) 1

Notes:

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
None Reported

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

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

WorkSite	Location
joseph m smith community health center	waltham , ma
Mount Auburn Hospital	

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2014	12/31/2014	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?
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Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

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

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

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

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Compliance with Legal Responsibilities

Online profile:

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

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

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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.

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

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[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: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:

330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
None Reported

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

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

WorkSite	Location
Mount Auburn Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2016	12/31/2016	Claims made with tail coverage

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

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22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

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

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

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

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

Compliance with Legal Responsibilities

Online profile:

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

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

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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2018

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
330 Mt. Auburn Street
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Massachusetts - 02139
United States of America
(617) 499-5161

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

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7) **Drug License Numbers**

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

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

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

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

WorkSite	Location
Mount Auburn Hospital	

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

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Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

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Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
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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: Mississippi State Board of Medical Licensure

ADDRESS: Cypress Ridge Building 15567 CraneRidge Drive Suite 200-B

CITY: Jackson STATE: MS ZIP: 39216

PHYSICIAN'S NAME: Cheryl Hamlin

BUSINESS ADDRESS: 330 Mount Auburn St

CITY: Cambridge STATE: MA ZIP: 02138

MASSACHUSETTS LICENSE NUMBER: 74421

SIGNATURE OF PHYSICIAN: [signature]

Signed under the penalties of perjury

DATE: 3/17/17

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

Date Received: 3/21/17
Check #: 1159
Check Amount: $ 10...
Initials: CR

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** please complete other side
☒ **The $10.00 fee has not been received and/or is incorrect**

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.)

RECEIVED

SEP 13 2019

Board of Registration in Medicine

SEND LICENSE

VERIFICATION TO: Alabama Board of Medical Examiners

ADDRESS:P.O Box 946

CITY: Montgomery STATE: AL ZIP: 36101

PHYSICIAN'S NAME: Cheryl L Hamlin

BUSINESS ADDRESS: 330 Mount Auburn Street

CITY: Cambridge STATE: MA

ZIP: 02138

EMAIL ADDRESS: [redacted]

MASSACHUSETTS LICENSE NUMBER: 74421

SIGNATURE OF PHYSICIAN:

Signed under the penalties of perjury

DATE: 9/5/19

Date Received: 9/13/19

Check #: 1427

Check Amount: $ 100.00

Initials: RF

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

Rev. 07/2019

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address: [redacted]

Home Address:

Business Address:
330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

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

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

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

WorkSite	Location
Mount Auburn Hospital	

Physician Name: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 10 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2020	12/31/2020	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 or physical condition that currently impairs your ability to practice medicine?** [redacted]

24) **Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?**

25) MassHealth Enrollment Status
I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

26) Domestic Violence and Sexual Violence Training Requirement
Have you completed training and education on the issue of domestic violence and sexual violence? Yes

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

☒ **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: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

Current Status: Active **License Expiration Date:** 6/15/2022

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
330 Mt. Auburn Street
Cambridge
Massachusetts - 02139
United States of America
(617) 499-5161

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

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

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

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

WorkSite	Location
Mount Auburn Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 10 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2022	12/31/2022	Occurrence Policy

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

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

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

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

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

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

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

23) **Do you have a medical or physical condition that currently impairs your ability to practice medicine? If your answer is 'yes', please provide a detailed explanation.**

You may answer 'NO' if the behavior or condition is known to the Massachusetts Medical Society's Physician Health Services (PHS) and you are complying with all PHS requirements for evaluation, treatment and/or monitoring as recommended.

[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? If your answer is 'yes', please provide a detailed explanation.**

25) Alzheimer's Training Requirement

I did not complete the required Alzheimer's and Dementia Training.

Licensees applying to renew a license must complete the required course by November 7, 2022.

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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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: Cheryl Lynn Hamlin, M.D. **License No.:** 74421

☒ **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.**