Application #: 268696
For Board Use Only

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

INITIAL LIMITED LICENSE APPLICATION

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

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

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

SECTION A: Sworn Statement to be completed by applicant

1-A. Name: (Last) Sobel (First) Lauren (MI) E

1-B. Other Name(s)____

	YES	NO
a) Since your graduation from medical school, have you ever been known under a different name or been licensed under a different name?	☐	☑
b) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☑

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

2. Current Address: [redacted] Telephone Number: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]

3. Date of Birth: [redacted] Place of Birth: [redacted]
Month Day Year

E-mail Address [redacted]

4. Sex: ☐ Male ☑ Female 5. U.S. Social Security Number: [redacted]

6. Name of Massachusetts Training Program: Boston Medical Center

One BMC Place — Boston, MA 02118
Street Address — City

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

Date Received: 5/27/16

Check #: 100475711

Check Amount: $ 100.00

Initials: LF

PRINT NAME Lauren Sobel

7. Name of premedical school(s): University of California, Santa Cruz

   Location: 1156 High St, Santa Cruz, CA 95064 USA
   (City, State, Country)

8. Name of medical school(s): Touro University, California

   Location: 1310 Club Dr, Vallejo, CA 94594 USA
   (City, State, Country)

   Date of Graduation: 6 /3 /16 Degree: ☐ M. D. ☑ D. O. Other (specify)_____
   Month Day Year

9. Have you ever or are you currently engaged in postgraduate training in the U.S. or Canada?

   ☐ Yes ☑ No

   Name of Postgraduate Training Program _____

   City: _____ State: _____

   Training Dates: From: ____/____/____ To: ____/____/____ Specialty: _____

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

10. List states (abbreviations) where you ever had a full license to practice medicine.

    _____

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

    USMLE: ☑ Step 1 ☑ Step 2 (CK) [ ] Step 2 (CS) ☐ Step 3

    COMLEX: ☑ Level 1 ☑ Level 2 (CE) ☑ Level 2 (PE) ☐ Level 3

    ☐ LMCC ☐ Other _____

	YES	NO
12. If you are a U.S. or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school? (Include leave of absence for research, public service, M.D./Ph.D program, and personal reasons, etc.) (Please request that your medical school also provide an explanation.)	[redacted]	
13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? (Include past or current training programs)		

PRINT NAME Lauren Sobel

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

This certifies that Lauren E. Sobel has been appointed
(Name of Applicant)

to the position of ☑ Intern ☐ Resident ☐ Fellow

in the specialty of OB/GYN as a PGY 1

Department: OB/GYN Subspecialty: _____

at Boston Medical Center
(Name of Healthcare Facility)

beginning 6 / 15 / 16 to anticipated completion of training: 7 / 1 / 20.
Month Day Year Month Day Year

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

Designated Official's Signature: _____

Type or Print Name: Jeffrey Schneider, MD

Official Title: Designated Institutional Official

Date: 5 / 24 / 16 Telephone Number: 617-414-7144

SECTION C: PAGES 4-7 MUST BE COMPLETED BY APPLICANT.

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Lauren Elizabeth Sobel
(type or print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature — Date of Signature: 05/03/2016

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

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

DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physicians Name: Lauren Sobel
First Name Middle Name Last Name

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

- [X] Medical school verification form
- [X] Medical school transcripts
- [ ] Letter from Program Director
- [ ] Evaluations
- [ ] Leave of absence
- [ ] Other documents (describe): _____

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

Designated Official: _____ Date: 5/23/16

Title: GME Coordiantor

Name of Institution: Boston Medical Center

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

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

LAUREN E. SOBEL

[redacted]

EDUCATION

08/2012- present	D.O., Touro University- California, College of Osteopathic Medicine, Vallejo, CA
05/2012- present	M.P.H., Touro University- California, College of Education and Health Sciences, Vallejo, CA
09/2004- 12/2008	B.S., University of California, Santa Cruz, Santa Cruz, CA

POST-GRADUATE TRAINING

06/2016- 06/2020 (Anticipated) Intern, Obstetrics & Gynecology, Boston Medical Center, Boston University, Boston, MA

PROFESSIONAL EXPERIENCE

03/2015- present	Chair, Strategic Planning Committee Medical Students for Choice, International Board of Directors, Philadelphia, PA
06/2014- present	Board Member at Large Medical Students for Choice, International Board of Directors, Philadelphia, PA
01/2016- 02/2016	Reproductive Health Externship Medical Students for Choice, University of California, Davis Medical Center, Sacramento, CA
10/2010- 03/2013	Staff Training Specialist Planned Parenthood, Shasta-Pacific, Concord, CA
02/2012- 03/2012	Introduction to Traditional Medicine Internship Child Family Health International, Uttarakhand, India
07/2009- 10/2010	Reproductive Health Specialist Planned Parenthood, Shasta-Diablo, Walnut Creek, CA
08/2008- 09/2008	Health Access and Inequities Internship Child Family Health International, Oaxaca, Mexico

VOLUNTEER EXPEREINCE

01/2008- 07/2009	Equine Therapy Volunteer Monterey Bay Horsemanship & Therapeutic Center, Aptos, CA
01/2008- 07/2009	Client Outreach Volunteer Santa Cruz AIDS Project, Santa Cruz, CA
08/2012- 05/2014	Student Physician Volunteer Touro University- California, Student Run Health Clinic, Vallejo, CA

INSTITUTIONAL SERVICE

06/2014- 06/2016	College of Medicine President, Class of 2016 Touro University- California, Student Government Association, Vallejo, CA
05/2013- 05/2014	President Medical Students for Choice, Touro University- California Chapter, Vallejo, CA
08/2012- 05/2013	Vice President of Community Outreach Medical Students for Choice, Touro University- California Chapter, Vallejo, CA

08/2012- 05/2013 Vice President
Obstetrics and Gynecology Interests Group, Touro University- California, Vallejo, CA

RESEARCH EXPERIENCE

06/2015- 08/2015 Research Assistant, Patient-Centered Support for Contraceptive Decision Making
University of California, San Francisco, Department of Family and Community Medicine
PI: Christine Dehlendorf, MD, MAS

01/2014- 03/2015 MPH Capstone Research, Contraception Counseling Training for Healthcare Professionals
Touro University- California, College of Education and Health Sciences
Advisor: Carinne Brody, DrPH, MPH, MA

06/2013- 08/2013 Research Intern, National Provider Database Project
University of California, San Francisco, Bixby Center for Global Reproductive Health, ANSIRH
PI: Ushma Upadhyay, PhD, MPH, Supervisor: Heather Gould, MPH

06/2009- 10/2010 Data Collection Assistant, Health Workforce Pilot Project #171
University of California, San Francisco, ANSIRH/ Planned Parenthood, Shasta-Diablo
PI: Tracy Wietz PhD, MPA, Supervisor: Jeffery Waldman, MD, PPSD Medical Director

TEACHING EXPERIENCE

2014 Community Teaching Assistant, Abortion: Quality Care and Public Health Implications
University of California, San Francisco, Coursera

2014 Lecturer, Public Health Implications of Patient-Centered Contraceptive Counseling
Touro University- California

2007 Teaching Assistant, Female Physiology and Gynecology
University of California, Santa Cruz

AWARDS and HONORS

2016 Reproductive Health Externship Scholarship, Medical Students for Choice
2015 Junior Fellowship, Society of Family Planning
2015 Gold Humanism Honor Society, Arnold P. Gold Foundation
2015 SGA Travel Funds Scholarship, Touro University- California
2014 Translating Osteopathic Understand into Community Health Sliver Award, Touro University- California
2011 Patient Service Award, Planned Parenthood, Shasta-Pacific
2008 Nancy Pascal Field Study Scholarship, University of California, Santa Cruz
2008 Undergraduate Dean's Award, University of California, Santa Cruz

PROFESSIONAL AFFILIATIONS

2015- present Society of Family Planning (SFP)
2014- present American Congress of Obstetricians and Gynecologists (ACOG)
2014- present Association of Reproductive Health Professionals (ARHP)
2014- present American Medical Association (AMA)
2012- present American Public Health Association (APHA)

PUBLICATIONS and ABSTRACTS

Dehlendorf, C., Fox, E., **Sobel, L.**, Borrero, S., Patient-Centered Contraceptive Counseling: Evidence to Inform Practice. Current Obstetrics and Gynecology Reports, March 2016. 5(1): p. 55-63.

Dugan, JA., **Sobel, L.**, Chiang, W., "Quick Recertification Series: Ovarian Torsion". Journal of the American Academy of Physician Assistants. (Publication Status: Accepted 2016)

PRESENTATIONS

Poster Presentations

Sobel, L., Brody, C., "Bridging the Gap: A Contraception Workshop for Healthcare Professionals", 13th Annual American Medical Association Research Symposium, Poster Presentation. Atlanta, GA, November 13, 2015.

Sobel, L., Brody, C., "Comprehensive Contraception Workshop and Evaluation: Pre-and Post-Intervention Evaluation of a Contraception Workshop for Osteopathic Medical Students and Allied Health Professional Students", 14th Annual Touro University Research Day. Poster Presentation. Vallejo, CA, April 29, 2015.

Sobel, L., Plant, M., "HIV Prevention Strategies for the High-Risk Migrant Population", Santa Cruz AIDS Project. Palo Alto Medical Foundation, Public Health Symposium. Poster Presentation. Santa Cruz, CA, June 2009.

Invited Presentations

Sobel, L., "Child Family Health International: Perspective on Primary Care in the United State", VIA Stanford Lecture Series. Stanford University. Palo Alto, CA, March 23, 2016.

Sobel, L., "Provider Panel: Five Abortion Providers Share Their Experiences with the Next Generation of Physicians", Panel Moderator. Conference on Family Planning, Philadelphia, PA, October 18, 2015.

Grand Round Presentations

Sobel, L., Thorsen, D., Armstrong, R. Chiang, W. "C. psitticai and C. immitis, Case Presentations and CDC Pneumonia Guidelines", Preceptor: Dr. K. Afsari MD, Grand Rounds Presentation. Doctors Medical Center, San Pablo; San Pablo, CA, August 5, 2014.

PUBLISHED MEDIA

Sobel, L., "The Ailing Hospital", KQED Perspectives, National Public Radio, San Francisco, CA. August 25, 2014. Radio. http://www.kqed.org/a/perspectives/R201408250735.

INTERESTS and ACTIVITIES

05/2012- present	Founder/ Owner of Lolo Granola, Berkeley, CA
03/2016- 04/2016	Herbs for Women Course, Ohlone Center of Herbal Medicine, Berkeley, CA
06/2007- 09/2007	Language and Culture Program, International Institute, Madrid, Spain

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

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

Print or Type Name: Sobel (Last Name) Lauren (First Name) E. (Middle Initial) U.S. Social Security No: [redacted]

Other Name(s): _____
(Please type or print.)

Name of Medical School: Touro University- California

Address: 1310 Club Drive City: Vallejo State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Santa Cruz

Undergraduate School Address: 1156 High Street, Santa Cruz, CA 95064

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

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	8 / 1 / 2012	5 / 31 / 2013	6 / 1 / 2015	5 / 31 / 2016
	8 / 1 / 2013	5 / 31 / 2014	/ /	/ /
	6 / 1 / 2014	5 / 31 / 2015	/ /	/ /

The applicant attended 176 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year.**

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

☒ will be awarded on 6 / 3 / 2016 **(Form B must also be completed and returned directly to the Board.)**

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

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates or did the applicant take any leaves of absence, (i.e. for research, public service, participation in an M.D./ Ph.D. program) or for any "personal reasons?		[redacted]
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: _____

Print Name: Dr. Ron Travenick

Title: Registrar

Date: 4 / 15 / 16 Telephone: (707) 638-5984

E-mail address: ron.travenick@tu.edu

Seal Verified DATE: 4/21/16 INITIALS: _____

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

PRINT NAME Lauren Sobel

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

		YES	NO
14.	While enrolled in college, medical school, graduate school or postgraduate training, were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.) **If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.**		[redacted]
15.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program, or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
16.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program? **If you answered "yes" to 15 or 16, you must provide an explanation and request a letter of explanation from your medical school, graduate school, or postgraduate training program.**		
17.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
18.	Have you ever been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
20.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity, or are any disciplinary charges pending against you?		
21.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		
22.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		

PRINT NAME Lauren Sobel

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

PRINT NAME Lauren Sobel

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

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

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

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

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

If your responses to Questions 15-34 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

PRINT NAME Lauren Sobel

CERTIFICATIONS

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)

- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.

- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00.

- To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: _____ Date: 05 / 03 / 2016

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

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

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

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

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

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

[redacted]

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

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

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

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

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program? No

6-B. Have you, for any reason, been placed on probation in any postgraduate training program? No

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination? No

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

22. MassHealth Enrollment Status

I am already enrolled with MassHealth as a nonbilling provider.

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. 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.

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

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

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? [redacted]

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

Name: Michelle Sia **Date:** 1/24/2019
Designation: Program Director **Telephone:** (617) 414-5678

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

This certifies that **Lauren E Sobel** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Corde Miller **Date:** 2/5/2019
Designated Official's Title: GME System Manager **Telephone:** (617) 414-7409

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

22. MassHealth Enrollment Status

I am already enrolled with MassHealth as a nonbilling provider.

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. 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.

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

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

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

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

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

Name: _____ **Date:** _____
Designation: _____ **Telephone:** _____

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

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

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

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

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

Is the above named physician in good standing in the training program? [redacted]

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

Name: Elisabeth Woodhams **Date:** 2/9/2017
Designation: **Telephone:** (617) 414-3821

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

This certifies that **Lauren E Sobel** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Corde Miller **Date:** 3/13/2017
Designated Official's Title: **Telephone:** (617) 414-7409

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

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

Physician Name: Lauren E Sobel, D.O. **License No.:** 268696

1. **Training Program**

   Current Training Program

   Facility: Boston Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America

   Home Address:
   Boston Medical Center
   1 Boston Medical Center Place
   Boston
   Massachusetts - 02118
   United States of America
   (617) 638-6800

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 268696

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

SECTION B: To be completed by the Program Director.

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

Has the physician been subject to past or pending disciplinary action in this Program? No

Name: Michelle Sia **Date:** 2/16/2018
Designation: Program Director **Telephone:** (617) 414-5678

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

This certifies that **Lauren E Sobel** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: [redacted]

Designated Official's Name: Corde Miller **Date:** 3/27/2018
Designated Official's Title: GME System Manager **Telephone:** (617) 414-7409

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

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

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

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

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

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

Compliance with Legal Responsibilities

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

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

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

4. I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

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

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

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

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

9. I will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

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

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that Lauren Sobel
(Student's Name)

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

from Touro University California
(Name of Medical School)

and will receive the degree on 6 / 3 / 2016.

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

Printed Name: Ron Travenick, EdD

Title: Registrar

Date: 5/18/2016

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

Thank you.

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that Lauren Sobel
(Student's Name)

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

from Touro University California
(Name of Medical School)

and will receive the degree on 6 / 3 / 2016.

Signature of Certifying Official: [signature]
(Original Signature is required – Stamps not accepted)

Printed Name: Ron Travenick, EdD

Title: Registrar

Date: 5/18/2016

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

Thank you.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Lauren E Sobel, D.O. **License No.:** 282363

Current Status: Active **License Expiration Date:** 10/8/2020

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
11 Newcomb St
Apt 15
Boston
Massachusetts - 02118
United States of America

Home Address:
11 Newcomb St
Apt 15
Boston
Massachusetts - 02118
United States of America
(925) 818-1461

Business Address:
75 Francis Street
Boston
Massachusetts - 02115
United States of America
(925) 818-1461

3) Email Address: lauren.e.sobel@gmail.com

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
None Reported			

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
MCS003470A	FS9222186	

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

9) States where you were previously licensed
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	

Physician Name: Lauren E Sobel, D.O. **License No.:** 282363

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 5 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	07/01/2020	12/31/2020	Claims made with tail coverage

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

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? No
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? No

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? No

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? No
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period? No

17) Criminal Charges
a) Have you been charged with any criminal offense during this period? No
b) Have any criminal offenses/charges against you been resolved during this time period? No
c) Are there any criminal charges pending against you today? No
d) Are any Application of Issuance of Process pending against you? No

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association? No
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? No
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? No
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? No

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? No

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? No

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? No

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? No

24) Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired? No

Physician Name: Lauren E Sobel, D.O. **License No.:** 282363

Office Based Surgery

Please indicate your office Facility Classification under the MMS office Based Surgery Guidelines

You indicated that you are a Level II office

Provide a brief description of the types of surgery performed in your office.

Outpatient GYN procedures

Are you in compliance with all requirements of the MMS as defined by the MMS Office Based Surgery guidelines and endorsed by the Board of Registration in Medicine? 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: Lauren E Sobel, D.O. **License No.:** 282363

☒ **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.**

PRINT NAME: Lauren Elizabeth Sobel

APPLICATION QUESTIONS

You must answer "yes" or "no" to questions #21 – 47.
NOTE: A "yes" response requires a detailed explanation on the *Explanation for Application Questions* page and submission of documentation related to the underlying occurrence from the appropriate institution.

	PRE-MEDICAL SCHOOL AND MEDICAL SCHOOL	YES	NO
21.	While enrolled in college, medical school or graduate school were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		[redacted]
22.	Have you ever been terminated from a medical school?		
23.	Have you ever withdrawn or transferred from a medical school?		
24.	Have you ever been granted a leave of absence by a medical school? (This includes a leave for research, public service, participated in a joint degree program such as an M.D./Ph.D. program, medical leave or for any other "personal reasons".)		
25.	Have you ever been placed on probation or remediation by a medical school or graduate school?		
26.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
	POSTGRADUATE TRAINING		[redacted]
27.	While enrolled in postgraduate training were you ever the subject of any disciplinary action or under investigation? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
28.	Have you ever been suspended, terminated or dismissed from any postgraduate training program?		
29.	Have you ever had to repeat a year of postgraduate training?		
30.	Have you ever withdrawn or transferred from a postgraduate training program?		
31.	Have you ever been granted a leave of absence from a postgraduate training program? (This includes a leave for research, public service, medical leave or for any other "personal reasons".)		
32.	Have you ever been placed on probation or remediation by a postgraduate training program?		
33.	Were any limitations or special requirements imposed on you because of questions of competency or disciplinary problems?		
34.	Did you ever receive partial or no credit for a postgraduate training program?		
35.	Have you ever had a postgraduate training program contract not be renewed?		

PRINT NAME: Lauren Elizabeth Sobel

	ACTIONS BY ANY HEALTHCARE FACILITY, EMPLOYMENT, PROFESSIONAL ORGANIZATION, STATE BOARD OR ANY OTHER GOVERNMENTAL AGENCY	YES	NO
36.	Have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		[redacted]
37.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
38.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
39.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
40.	Are you aware of any open complaint, pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
41.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		
42.	Since your completion of postgraduate training, have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competency to practice medicine?		
43.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
44.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
45.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
46.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
47.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		

PRINT NAME: Lauren Elizabeth Sobel

EXPLANATION FOR APPLICATION QUESTIONS

This form must be used to provide a detailed written explanation for a "yes" response to Questions # 21 - 47 on the application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each question.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the appropriate agency or institution to submit copies of all official documentation related to any "yes" response to a question on the Application. Documentation should be sent directly to the Board or to you in a sealed envelope.

Application Question Number: _____ (List the corresponding question number - # 21 - 47)

Name of agency or institution taking action: _____

Date(s): _____ _____ _____ - _____ _____ _____

Please provide a detailed explanation:

PRINT NAME: Lauren Elizabeth Sobel

MEDICAL MALPRACTICE HISTORY QUESTION			
You must answer "yes" or "no" to question #48. **NOTE: A "yes" response requires a detailed explanation of each malpractice claim. Please use the *Explanation for Malpractice History Question.* You must also arrange for your lawyer or liability carrier to provide the requested supporting documentation.**		**YES**	**NO**
48.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim? **NOTE:** You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.	[redacted]	

CRIMINAL HISTORY QUESTION			
You must answer "yes" or "no" to question #49. **NOTE: A "yes" response requires a detailed explanation of each offense/arrest. Please use the *Explanation for Criminal History Question.* You must also arrange for submission of the court and police records directly from the primary source or from your lawyer.**		**YES**	**NO**
49.	Have you ever been charged with any criminal offense? **NOTE:** You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. Minor traffic or parking violations need not be reported. You must report serious traffic offenses such as reckless driving, hit and run, driving with a suspended license, or operating under the influence or its equivalent. This list is not all-inclusive. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application. A medical malpractice claim is a civil, not a criminal matter and should not be reported on this question. Expunged/Sealed Offenses: While expunged/sealed offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.	[redacted]	

PRINT NAME: Lauren Elizabeth Sobel

EXPLANATION FOR MALPRACTICE HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #48 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each malpractice claim.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for your lawyer or liability carrier to provide the following documents directly to the Board or to you in a sealed envelope:

Pending Claim: 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant's name/initials and confirmation that the claim is open/pending; and 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter.

Closed Claim: 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant's name/initials and confirmation that the claim is closed ; 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter; and 3) a copy of the final judgment, settlement and release or other final disposition of the claim, even if you were dismissed from the case by the court.

GENERAL CLAIM INFORMATION:

Claimant's name/initials: _____

Date of incident: _____ _____ _____

Professional Liability Carrier: _____

Legal representative's name: _____

STATUS OF CLAIM:

Current status of claim: ☐ Closed ☐ Pending

Was a lawsuit filed in relation to the claim: ☐ Yes ☐ No

If the claim resulted in a lawsuit, what was the final outcome of the suit?

☐ Dismissed before trial ☐ Judgment for Defendant ☐ Judgement for Plaintiff

☐ Other (please specify) _____

Was the claim settled by you or on your behalf? ☐ Yes ☐ No

If a payment was made on your behalf, either as a result of a settlement or an award of damages:

Amount allocated to you: $_____

(***Explanation for Malpractice History Question*** **continued on the next page)**

PRINT NAME: Lauren Elizabeth Sobel

MALPRACTICE EXPLANATION CONTINUED

MALPRACTICE CLAIM DESCRIPTIVE INFORMATION:

Allegation(s): _____

_____

Alleged Patient Injury: _____

_____

Condition of Patient When You Began Treatment: _____

_____

Condition of Patient at the End of Treatment: _____

_____

Detailed Summary: Provide a detailed narrative of the clinical course and circumstances leading to the claim, including the nature and extent of your involvement and role in patient the care.

PRINT NAME: Lauren Elizabeth Sobel

EXPLANATION FOR CRIMINAL HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #49 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, "See attached;" you must provide your response on this form.
A separate form is to be used for each criminal offense/arrest.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the following to be sent directly to the Board or to you in a sealed envelope:

1) **Court Records:** The appropriate court or your lawyer must send certified copies of all court records related to the offense; and **2) Police Records:** The appropriate arresting/ticketing agency or your lawyer must send certified copies of the arrest/offense/incident report or citation/ticket.

*If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of the applicable records, request that they furnish a written statement to that effect.

Incident Date: _____ _____ _____

Location of Incident (City and State/Country): _____

Arresting/Ticketing Agency: _____

Court: _____

Initial Charge(s): _____

☐ Misdemeanor ☐ Felony

Final Charge(s): _____

☐ Misdemeanor ☐ Felony

Plea: _____

Disposition: (if probation, deferred adjudication, or deferred prosecution give summary.)

Detailed Summary. Provide a personal statement containing a detailed summary of the events and circumstances leading to the criminal offense:

PRINT NAME: Lauren Elizabeth Sobel

CONFIDENTIAL INFORMATION QUESTIONS			
For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years. You must answer "yes" or "no" to questions #50 - 52. **NOTE: A "yes" response to questions # 50 - 52 requires a detailed explanation. Please use the *Explanation for Confidential Information Questions.***		**YES**	**NO**
50.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		[redacted]
51.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
52.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

**** IMPORTANT NOTE REGARDING PHYSICIAN WELLNESS ****

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

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

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

PHS is a nationally recognized physician assistance program designed to assist physicians with the following: alcohol misuse; substance use disorder; behavioral or mental or physical health issues that currently impair the ability to practice medicine; stress including administrative burdens; financial pressures; and work-family balance issues. PHS does not treat but may refer a physician for evaluation and treatment, if necessary. PHS services are available to all physicians in Massachusetts, whether or not they belong to the Massachusetts Medical Society.

PRINT NAME: Lauren Elizabeth Sobel

EXPLANATION FOR CONFIDENTIAL INFORMATION QUESTIONS

QUESTION #50 – Medical or physical condition.

Please provide the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program.

QUESTION #51 – Substance use.

If you have obtained medical treatment related to your use of substances, please provide the specifics of your treatment, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

QUESTION #52 - Refusal to take a screening test for chemical substances.

Please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

PRINT NAME: Lauren Elizabeth Sobel

TIMELINE OF ACTIVITIES SINCE GRADUATION FROM MEDICAL SCHOOL

Please provide a chronological listing by month and year of ALL activities since graduation from medical school. You must include postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Do not write, "See CV" or "See attached"; you must complete this section AND attach your curriculum vitae. If you need additional rows, please print additional copies of this page. **You MUST account for any time gaps of 30 days or more since your graduation from medical school. (*For example, if you graduated from medical school on May 31, 2015 and started residency on July 1, 2015, you must account for this gap of 30 days.*)**

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Position Held** (Resident, Attending, Research Fellow, etc.)	**Institution/Place of Employment**	**City, State/Country**
05/2016 (Month / Year)		**Medical School Graduation Date** *(start timeline from this date)*		
06/2016	06/2020	Resident, Obstetrics and Gynecology	Boston Medical Center	Boston, MA/ USA
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			
__/__	__/__			

LAUREN E. SOBEL

[redacted]

EDUCATION

2012- 2016	DO, Touro University- California, College of Osteopathic Medicine, Vallejo, CA
2012- 2016	MPH, Community Action Concentration, Touro University- California, College of Education and Health Sciences, Vallejo, CA
2004- 2008	BS, Health Sciences, University of California, Santa Cruz, Santa Cruz, CA

TRAINING

6/2016- present	Residency, Obstetrics and Gynecology, Boston Medical Center, Boston University, Boston, MA *Ambulatory Chief Resident, AY 2019-2020*

PROFESSIONAL DEVELOPMENT

3/2018	Council on Resident Education in Obstetrics and Gynecology (CREOG) Leadership Conference, Los Angeles, CA
8/2017	Gottesfield-Hohler Resident Ultrasound Course, Mount Sinai Health System, New York, NY

LICENSURE and CERTIFICATION

2016	Massachusetts Medical License, Limited
2018	Fundamentals of Laparoscopic Surgery Certification

AWARDS and HONORS

2019	The Ryan Program Resident Award for Excellence in Family Planning, *Boston Medical Center*
2019	Resident Leader in Women's Gynecologic Care, *Lahey Hospital and Medical Center*
2018	Society of Maternal Fetal Medicine, Excellence in Obstetrics, *Boston Medical Center*
2015	Gold Humanism Honor Society, Arnold P. Gold Foundation, *Touro University California*
2015	Student Government Association Merit Scholarship, *Touro University California*
2014	Translating Osteopathic Understanding into Community Health, *Touro University California*
2011	Patient Service Award, *Planned Parenthood, Shasta-Pacific*
2008	Nancy Pascal Field Study Scholarship, *University of California, Santa Cruz*
2008	Undergraduate Dean's Award, *University of California, Santa Cruz*

PROFESSIONAL EXPERIENCE

10/2010- 3/2013	**Planned Parenthood, Shasta-Pacific,** Concord, CA *Staff Training Specialist*
2/2012- 3/2012	**Child Family Health International**, Uttarakhand, India *Traditional Medicine Internship*
7/2009- 10/2010	**Planned Parenthood Shasta-Diablo,** Walnut Creek, CA *Reproductive Health Specialist*
8/2008- 9/2008	**Child Family Health International,** Oaxaca, Mexico *Health Access and Inequities Internship*

1/2008- 6/2009 **Santa Cruz AIDS Project,** Santa Cruz, CA
Client Outreach Coordinator

SERVICE

3/2019- present **Lynne Stevens Memorial Committee, Boston Medical Center for Domestic Violence,** Boston, MA
Committee Member

6/2018- present **Advocacy Committee, Dept of Obstetrics & Gynecology, Boston Medical Center,** Boston, MA
Committee Member

6/2017- present **Opioid Working Group, Center for Health Equity, Boston Medical Center,** Boston, MA
Member

3/2015- 6/2016 **Medical Students for Choice, National Board of Directors,** Philadelphia, PA
Chair, Strategic Planning Committee

6/2014- 6/2016 **Touro University-California, College of Osteopathic Medicine,** Vallejo, CA
Student Government President

6/2014- 6/2016 **Medical Students for Choice, National Board of Directors,** Philadelphia, PA
Board Member at Large

5/2013- 5/2014 **Medical Students for Choice, Touro University California**, Vallejo, CA
Chapter President

RESEARCH EXPERIENCE

6/2018- present **Contraceptive Preferences and Experiences Among Women with Opioid Use Disorder**
Principal Investigator
Department of Obstetrics & Gynecology, Boston Medical Center

6/2016- present **Labor & Delivery Experience of Women with a History of Sexual Trauma**
Principal Investigator
Department of Obstetrics & Gynecology, Boston Medical Center

6/2015- 8/2015 **My Birth Control: A Contraceptive Counseling Decision Support Tool**
Research Assistant, responsible for participant screening and data collection
Program in Woman-Centered Contraception, University of California, San Francisco
PI: Christine Dehlendorf, MD, MAS

6/2013- 8/2013 **National Provider Database Project**
Research Intern, responsible for protocol development, database design, and pilot data collection
Advancing New Standards in Reproductive Health (ANSIRH), University of California, San Francisco
PI: Ushma Upadhyay, PhD, MPH

PUBLICATIONS

O'Rourke-Suchoff, D., **Sobel, L.,** Holland, E., Perkins, R., Saia, K., Bell, S. (2019). The Labor and Birth Experience of Women with Opioid Use Disorder: A Qualitative Study. Women and Birth *[Submitted]*

Sobel, L., O'Rourke-Suchoff, D., Holland, E., Remis, K., Resnick, K., Perkins, R., Bell, S. (2018). Pregnancy and Childbirth After Sexual Trauma: Patient Perspectives and Care Preferences. Obstetrics and Gynecology, 132(6), 1461–1468.

Dale, AG., Holbrook, BD., **Sobel, L.,** Rappaport, VJ. (2017). Hyperparathyroidism in Pregnancy Leading to Pancreatitis and Preeclampsia with Severe Features. Case Reports in Obstetrics and Gynecology, 2017, 6061313.

Dehlendorf, C., Fox, E., **Sobel, L.,** Borrero, S. (2016). Patient-Centered Contraceptive Counseling: Evidence to Inform Practice. Current Obstetrics and Gynecology Reports, 1(5), 55–63.

Dugan, J., Chiang, W., **Sobel, L.** (2016). Ovarian Torsion. JAAPA: Official Journal of the American Academy of Physician Assistants, 29(12), 57–58.

Curriculum Evaluation

Sobel, L., Shea, C., Sommer, B., Blau, C., Brody, C. (2016). Bridging the Gap: A Contraception Counseling Workshop for Healthcare Professionals. MedEdPublish, 5(2).

PRESENTATIONS

National Presentations

10/2019	**Sobel, L.,** Lee, YW., Woodhams, E., White, KO, Patton, EW. "Contraceptive Needs and Preferences Among Women with Opioid Use Disorder: A Qualitative Study," Oral Abstract, Society of Family Planning Annual Meeting, Los Angeles, CA.
4/2018	**Sobel, L.,** O'Rourke-Suchoff, D., Remis, K., Sia, M., Saia, K., Bell, S. "A Qualitative Study of Pregnancy and Birth Experience for Women with Opioid Use Disorder and a History of Sexual Trauma," Poster, ACOG Annual Clinical and Scientific Meeting, Austin, TX
4/2018	O'Rourke-Suchoff, D., **Sobel, L.**, Holland, E., Resnick, K., Perkins, R., Bell, S. "A Qualitative Study of Pregnancy and Childbirth Experience for Women with a History of Sexual Trauma," Poster, ACOG Annual Clinical and Scientific Meeting, Austin, TX
11/2015	**Sobel, L.,** Brody, C. "Bridging the Gap: A Contraception Workshop for Healthcare Professionals," Poster, 13th Annual American Medical Association Research Symposium, Atlanta, GA

Regional Presentations

4/2015	**Sobel, L.,** Brody, C. "Comprehensive Contraception Workshop and Evaluation: Evaluation of a Contraception Workshop for Osteopathic Medical Students and Allied Health Professional Students," Poster, 14th Annual Touro University Research Day, Vallejo, CA
6/2009	**Sobel, L.,** Plant, M. "HIV Prevention Strategies for the High-Risk Migrant Population," Poster, Santa Cruz AIDS Project, Palo Alto Medical Foundation, Public Health Symposium, Santa Cruz, CA

CONFERENCES

Institutional Conferences

6/2019	**Sobel, L.,** "Contraceptive Needs and Preferences Among Women with Opioid Use Disorder." Linda J. Heffner Resident Research Day, Department of Obstetrics & Gynecology, Boston Medical Center, Boston, MA
8/2018	**Sobel, L.,** O'Rourke-Suchoff, D. "What Have Our Patients Told Us About Providing Trauma Informed Care?" Department of Obstetrics & Gynecology, Summer Advocacy Series, Boston Medical Center, Boston, MA

2/2018	**Sobel, L.** "Examining Medicaid's 'Consent to Sterilization' Historical and Present-Day Context," Department of Obstetrics and Gynecology Grand Rounds, Boston Medical Center, Boston, MA
1/2017	Yasuda, J., **Sobel, L.** "Pediatric Urethral Prolapse: The Pediatric Female External Genital Exam," Department of Pediatrics Grand Rounds, Boston Medical Center, Boston, MA
5/2014	**Sobel, L**. Thorsen, D., Armstrong, R. Chiang, W. "C. psitticai and C. immitis, Case Presentations and CDC Guidelines," Department of Medicine Grand Rounds, Doctors Medical Center, San Pablo, CA

Invited Lectures

8/2018	**Sobel, L.** "What Providers Can Do to Support Women with a History of Sexual Trauma During Pregnancy & Childbirth," Grand Rounds, Boston Healthcare for the Homeless Project, Boston, MA
6/2018	**Sobel, L.** "What Providers Can Do to Support Women with a History of Sexual Trauma During Pregnancy & Childbirth," 2018 Lynne Stevens Memorial Lecture, Boston Medical Center, Boston, MA
3/2016	**Sobel, L.** "Child Family Health International: Perspective on Primary Care in the United States," VIA Stanford Lecture Series. Stanford University, Palo Alto, CA
10/2015	**Sobel, L.** "Provider Panel: Five Abortion Providers Share Their Experiences with the Next Generation of Physicians," Panel Moderator. Medical Students for Choice, Conference on Family Planning, Philadelphia, PA

EXTRAMURAL SUPPORT

2018	Emerging Scholars in Family Planning, Society of Family Planning, $7,490 *Contraceptive Preferences and Experiences Among Women with Opioid Use Disorder*
2017	Lynne Stevens Practice Improvement Grant, Boston University, $5,008 *Labor & Delivery Experiences for Women with a History of Sexual Violence*

SERVICE TO PROFESSIONAL PUBLICATIONS

1/2019- present	Obstetrics & Gynecology, Manuscript Reviewer

TEACHING EXPERIENCE

2017	Advocating for the Obstetrics & Gynecology Patient, Lecture, Boston University, School of Medicine
2014	Community Teaching Assistant, Abortion: Quality Care and Public Health Implications, Coursera, University of California, San Francisco
2007	Biology 80A: Female Physiology, Teaching Assistant, University of California, Santa Cruz

POLICY EXPERIENCE

12/2017	**Sobel, L.,** Markenson, G., Shapiro, F. Resolution I-17 B-201: Unbundling Postpartum Contraception from the Global Delivery Payment in Massachusetts. Massachusetts Medical Society. Approved.

PUBLISHED MEDIA

2/2019	**Sobel, L.,** O'Rourke-Suchoff, D. "Providing Obstetric Care for Women with a History of Sexual Trauma" MD Magazine. Accessible at: www.mdmag.com/medical-news/providing-obstetric-care-women-history-sexual-trauma.
8/2014	**Sobel, L.** "The Ailing Hospital" KQED Perspectives, National Public Radio, San Francisco, CA. Accessible at: http://www.kqed.org/a/perspectives/R201408250735.

PROFESSIONAL AFFILIATIONS

2018- present	American Association of Gynecologic Laparoscopists (AAGL)
2017- present	Massachusetts Medical Society (MMS), Suffolk District Delegate
2015- present	Society of Family Planning (SFP), Junior Fellow
2014- present	American Congress of Obstetricians and Gynecologists (ACOG)
2014- present	American Medical Association (AMA)
2013- present	American Public Health Association (APHA)

#282363

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

FULL LICENSE APPLICATION

Non-refundable Application Fee: A $600.00 check or money order payable to the Commonwealth of Massachusetts must be included with your full license application.

TYPE OF APPLICATION

(Check One)	(Check One)
☑ Initial Full License	☑ U.S. or Canadian Medical School Graduate
☐ Administrative License	☐ International Medical School Graduate
☐ Volunteer License	

FCVS Are you submitting primary source documentation (medical education, previous postgraduate training, etc.) for licensure through FCVS? ☐ Yes ☑ No

PERSONAL INFORMATION

1. Legal Name	Last: Sobel	First: Lauren	Middle: Elizabeth	Suffix:
2. Other Name(s) List other names that appear on your application documents (medical education, exams, etc.)				
3. Degree Type	☐ M.D. ☑ D.O. ☐ Other degree: MPH			
4. Social Security Number	569972552	**5. Gender**	☐ Male ☑ Female	
6. NPI Number	1184087199			
7. Date of Birth	[redacted] Month Day Year	**8. Place of Birth**	City/State: [redacted]	Country if not USA:
9. Mailing Address This address will be used for correspondence	Number and Street: [redacted]			
	City: [redacted]	State/Province/Territory:	Zip (or postal) Code:	
10. Home Address	Number and Street: [redacted]			
	City: [redacted]	State/Province/Territory:	Zip (or postal) Code:	
11. Business Address	Number and Street:			
	City:	State/Province/Territory:	Zip (or postal) Code:	
12. Telephone Numbers	Home #:	Business #:	Cell #: [redacted]	
13. Email Address Will be used for correspondence	[redacted]			

Date Received: 12/17/19

Check #: 157

Check Amount: $ 600.00

Initials: [signature]

PRINT NAME: Lauren Elizabeth Sobel

Questions #14 – 16 are optional. This information will assist the Board in processing your application.	
14.	**Reason for requesting a Massachusetts medical license:** Family Planning Fellowship in MA
15.	**Name of anticipated practice location/facility:** Brigham & Women's Hospital Address: 75 Francis St City: Boston, MA 02115
16.	**Anticipated starting date in Massachusetts:** July 1, 2020

U.S. OR CANADIAN MEDICAL LICENSURE	
17.	**If you currently or have ever held a full license in the U.S. or Canada list the state/province abbreviation. This includes any active or inactive licenses. Do not report training or temporary licenses.** **NOTE: You must provide license verifications for every active or inactive full license issued to you in the U.S. or Canada. Verifications must be received in a sealed envelope, electronically from the licensing authority or through Veridoc.**

PRACTICE SPECIALTY	
18.	**List the medical specialt(ies) that you practice. If you are completing postgraduate training, list that specialty here. The specialties listed will be included on your Physician Profile on the Board's website to help consumers locate physicians in specific specialties.**
	Obstetrics & Gynecology

ABMS/AOA BOARD CERTIFICATION	
19.	**Are you certified by the American Board of Medical Specialties (ABMS)?** ☐ Yes ☑ No If "Yes", list Board Certification(s):
20.	**Are you certified by the American Board of Osteopathic Medicine (AOA)?** ☐ Yes ☑ No If "Yes", list Board Certification(s):

PRINT NAME: Lauren Elizabeth Sobel

EXAMINATION HISTORY

Please note below each medical licensure examination you have taken.

NOTE: Please contact the appropriate entity and have the exam scores sent to you in a sealed envelope or sent electronically to the Board. If you are using FCVS, your exam scores will be sent to the Board directly.

***Examination Requirements:* (Please see Application Instructions for more information regarding eligibility.)**

- **7 Year Time Limit: All Steps of the USMLE and all Levels of the COMLEX must be completed within 7 years. The Board may, in certain circumstances, grant a waiver of the 7 year time limit.**
- **Step/Level Attempt Limit: Each USMLE Step/COMLEX Level must be passed by the 4th attempt. No waiver is available for applicants that did not pass a Step/Level by the 4th attempt.**
- **Step 3/Level 3 Attempt Limit: If an applicant failed Step 3/Level 3 on the 3rd attempt, he/she must complete a year of ACGME/AOA postgraduate training prior to his/her 4th attempt. The Board may, in certain circumstances, grant a waiver of this requirement.**

Examination	Number of attempts	Passed (P) or Failed (F)	
USMLE Step I	1	☑ P	☐ F
USMLE Step II CK	1	☑ P	☐ F
USMLE Step II CS		☐ P	☐ F
USMLE Step III		☐ P	☐ F
NBME Part I		☐ P	☐ F
NBME Part II		☐ P	☐ F
NBME Part III		☐ P	☐ F
FLEX Component 1		☐ P	☐ F
FLEX Component 2		☐ P	☐ F
FLEX Pre-1985		☐ P	☐ F
COMLEX Level 1	1	☑ P	☐ F
COMLEX Level 2 CE	1	☑ P	☐ F
COMLEX Level 2 PE	1	☑ P	☐ F
COMLEX Level 3	1	☑ P	☐ F
MCCQE – Part I		☐ P	☐ F
MCCQE – Part II		☐ P	☐ F
State Board Exam	State of Examination:	☐ P	☐ F

PRINT NAME: Lauren Elizabeth Sobel

PRE-MEDICAL SCHOOL

A minimum of two or more academic years at a legally-chartered college or university is required. For international medical graduates, this education may be incorporated into your medical school training. If not, please indicate the school(s) where you completed this requirement.

Name of School	Degree	Dates of Attendance (Year)
University of California, Santa Cruz	Bachelor of Science	2004 To 2009
	City: Santa Cruz, CA	State/Country

Name of School	Degree	Dates of Attendance (Year)
		To
	City	State/Country

MEDICAL SCHOOL

List all medical schools of attendance regardless of whether a degree was awarded.

Medical School Name	Degree
Touro University Califronia, College of Osteopath	DO, MPH
Street	**City, State**
1310 Club Dr	Vallejo, CA

Medical School Name	Degree
Street	**City, State**

Medical School Name	Degree
Street	**City, State**

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

MEDICAL EDUCATION VERIFICATION – FORM A

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

Waiver for Release of Information

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

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

Print or Type Name: Sobel (Last Name) Lauren (First Name) E. (Middle Initial) U.S. Social Security No: [redacted]

Other Name(s): _____
(Please type or print.)

Name of Medical School: Touro University- California

Address: 1310 Club Drive City: Vallejo State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of Santa Cruz

Undergraduate School Address: 1156 High Street, Santa Cruz, CA 95064

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

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

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	8 / 1 / 2012	5 / 31 / 2013	6 / 1 / 2015	5 / 31 / 2016
	8 / 1 / 2013	5 / 31 / 2014	/ /	/ /
	6 / 1 / 2014	5 / 31 / 2015	/ /	/ /

The applicant attended 176 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year.**

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

☒ will be awarded on 6 / 3 / 2016 **(Form B must also be completed and returned directly to the Board.)**

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

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates or did the applicant take any leaves of absence, (i.e. for research, public service, participation in an M.D./ Ph.D. program) or for any "personal reasons?		[redacted]
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: _____

Print Name: Dr. Ron Travenick

Title: Registrar

Date: 4 / 15 / 16 Telephone: (707) 638-5984

E-mail address: ron.travenick@tu.edu

Seal Verified DATE: 4/21/16 INITIALS: _____

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

Form B

Medical School Verification Form

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

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

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

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

My signature below certifies that Lauren Sobel
(Student's Name)

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

from Touro University California
(Name of Medical School)

and will receive the degree on 6 / 3 / 2016.

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

Printed Name: Ron Travenick, EdD

Title: Registrar

Date: 5/18/2016

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

Thank you.

Sealed Envelope

Initials:

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT INSTRUCTIONS: Primary source verification of ALL postgraduate training is required. Complete the Authorization and forward the form to your program director. If submitting verification of your training through FCVS, this form does not need to be completed.

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

Applicant's Signature: _____ Date: 11/26/2019

Print Name: Lauren E. Sobel

Institution: Boston Medical Center City/State: Boston, MA

PROGRAM DIRECTOR SECTION

Name of Institution: Boston Medical Center

Institution name if different when applicant attended: _____

Verification for (Print applicant's name): Lauren E. Sobel (WF) 2/14/20

Program Director Instructions:

Report incomplete years separate from completed years.

If the training year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

If more space needed, please use additional forms.

PGY(s): # 1 **Specialty/Subspecialty:** OB/GYN
☑ Internship ☐ Residency ☐ Fellowship
From: 06 26 2016 **To:** 06 25 2017
Successfully Completed? ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ None

PGY(s): # 2 **Specialty/Subspecialty:** OB/GYN
☐ Internship ☑ Residency ☐ Fellowship
From: 06 26 2017 **To:** 06 25 2018
Successfully Completed? ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ None

PGY(s): # 3 **Specialty/Subspecialty:** OB/GYN
☐ Internship ☑ Residency ☐ Fellowship
From: 06 26 2018 **To:** 06 25 2019
Successfully Completed? ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ None

PGY(s): # 4 **Specialty/Subspecialty:** OB/GYN
☐ Internship ☑ Residency ☐ Fellowship
From: 06 26 2019 **To:** 06 25 2020
Successfully Completed? ☐ Yes ☐ No ☑ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ CFPC ☐ None

(Continued on next page)

APPLICANT'S NAME: Lauren E. Sobel

Unusual Circumstances:

The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **If you answer "yes" to any of these questions, please provide an explanation in the space below or enclose a separate page.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?		[redacted]
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

Explanation for any "YES" answers:

CERTIFICATION AND SEAL

SEAL / NOTARY
If the institution does not have a seal, this form must be notarized.

Seal Verified
Date: 12/10/19
Initials: AT

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Program Director Signature: [signature]

Print Name: Michelle Sia, DO

Academic Title: Assistant Professor

Date: 11 25 2019 Telephone: 617-414-5678

E-mail address: Michelle.Sia@BMC.org

RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

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Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

Sealed Envelope

Initials:

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. You may use the same physician to complete both the Supervisory Evaluation Form and the Certificate of Moral and Professional Character, if they have known you for at least one year and are not a relative.

CERTIFYING PHYSICIAN INSTRUCTIONS:

- **Please complete the below certification.**
- **Return to the applicant in a sealed envelope with your name affixed across the envelope seal.**

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Lauren E. Sobel
(print name of applicant)

for 4 **years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.**

SIGNATURE: _____ **DATE:** 11/25/2019

Print Name: Michelle Sia, DO

License Number: 236496 **State:** MA

Address: One ~~Boston~~ Medical Center Place

City: Boston **State:** MA **Zip:** 02118

Email: Michelle.Sia@BMC.org

RETURN THE COMPLETED CERTIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

PRINT NAME: Lauren Elizabeth Sobel

STATUTORY AND REGULATORY REQUIREMENTS FOR LICENSURE

NOTE: You must complete the following requirements. Please see the Instructions for further information.

53. Opioid and Pain Management Training: (You must check one.)

- ☑ I completed three (3) credits of Board-approved CME credit in effective pain management. (i.e., www.opioidprescribing.com)
- ☐ I do not prescribe controlled substances (Schedules II – VI).

54. Child Abuse or Neglect Recognition and Reporting Training: (You must check one.)

- ☑ I received training in child abuse and neglect assessment in medical school or postgraduate training.
- ☐ I completed a hospital sponsored training program in recognizing the signs of child abuse and neglect.
- ☐ I completed a CME program in identifying and reporting child abuse and neglect.
- ☐ I completed an online training program (i.e. The Middlesex Children's Advocacy Center's program "51A Online Mandated Reporter Training: Recognizing and Reporting Child Abuse, Neglect and Exploitation" www.middlesexcac.org/51A-reporter-training).
- ☐ I completed a specialized certification (i.e., Child Abuse Pediatrics)

55. Domestic and Sexual Violence Education and Training: (You must complete.)

- ☑ I completed the Massachusetts Department of Public Health online training in Domestic and Sexual Violence for licensed healthcare professionals. https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

56. MassHealth Enrollment Requirement: (You must check one.)

- ☐ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider. (Nonbilling application: https://www.mass.gov/files/documents/2018/10/09/pe-nbp.pdf)
- ☑ I am enrolled or have applied to enroll in MassHealth as a billing provider. (Billing provider application must be requested through MassHealth at 1-800-841-2900)

57. Electronic Health Records (EHR) Proficiency Requirement: (You must check one.)

I have DEMONSTRATED PROFICIENCY in the use of EHR through my:

- ☐ participation in a Meaningful Use program as an eligible professional.
- ☑ my employment with, credentials to provide patient care at, or contractual agreement with an eligible hospital or critical access hospital that has implemented an electronic health record.
- ☐ participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
- ☐ completion of 3 hours of a Category 1 EHR-related CME course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

OR

I am EXEMPT from the EHR Proficiency requirement because I am an applicant:

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

PRINT NAME: Lauren Elizabeth Sobel

90-DAY RENEWAL INFORMATION

State law requires that renewal of your license occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday.

Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your license is issued on January 1, 2014, you will be required to renew your license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle.

Check one:

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

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

My birthday is: [redacted]
Month Day Year

CERTIFICATIONS

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

Certification:

☑ **I confirm I have read and agree to comply with these statutory and regulatory requirements.**

DECLARATION OF APPLICANT

I, Lauren Elizabeth Sobel :

(PRINT LEGAL NAME)

being duly sworn, depose and say that I am the person described and identified in this application. I declare that I have examined this complete application and to the best of my knowledge and belief, the information contained herein and evidence or other credentials submitted herewith are true, correct and complete. **I understand that any falsification or misrepresentation of any item or response on this application or any attachment hereto may be a sufficient basis for denying or revoking a license.** I hereby request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine. I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine. I hereby authorize the Board of Registration in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, or individual, who, in the judgement of the Board, has a legitimate interest in such information.

SIGNATURE: _____ **DATE:** 12/03/2019

PHOTOGRAPH

SIGNATURE OF APPLICANT:

_____

(Sign in the presence of a notary)

NOTARY SECTION

Seal Verified
Date: 12/18/19
Initials:

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

On this 3rd day of December, 2019, before me, the undersigned notary public, personally appeared Lauren Sobel (name of document signer), proved to me through satisfactory evidence of identification, which were Driver's license, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____
Signature of Notary Public

04/10/2020
Commission Expires On

NOTARY SEAL