90-Day Form

Dear Doctor,

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

Thank you.

Please select one of the boxes below:

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

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

My birthdate is [redacted]
Month Day Year

Signature: _____

Today's Date: 12 / 27 / 2018
Month Day Year

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

278195

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: $600.00 check or money order payable to the Commonwealth of Massachusetts.

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

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

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

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

McKinney Sara Ann
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

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

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

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

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

NPI (National Provider Identifier) Number: 1558708297

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

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

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

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

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

Date Received: 1 / 8 / 19

Check #: 1432417523

Check Amount: $ 600.00

Initials: RF

Business Address: 330 Brookline Ave, East Campus, Kirstein 3 Telephone: 617-667-3736
Number and Street

Boston MA 02215
City State/Province/Territory Zip (or postal) Code

Email Address: Sara Amckinney@gmail.com Fax number: 617-667-7493

*** The Board will use your Email and/or Mailing Address for all correspondence**

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

Name: Boston College Degree: n/a Year: 2006 Year: 2007
Street: 140 commonwealth Avenue City: Chestnut Hill State: MA

Name: Scripps College Degree: BA Year: 2007 Year: 2010
Street: 1030 columbia Avenue City: claremont State: CA

Medical School

Name: University of California Davis, School of Medicine Degree: MD
Street: Education Building, 4610 X street City: Sacramento State: CA.

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

Medical School Graduation Date: 06 / 2015
Month Year

Examination History

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

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

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

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. This would include all postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, military assignments, 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. You must account for any time gaps of 30 days or more since your graduation from medical school. Failure to complete this section or address any time gaps may result in delay of licensure. Attach a separate sheet of paper if necessary. Do not write, "See CV" or "See attached"; you must complete this section AND attach your curriculum vitae. If none, enter "N/A".

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Institution/Place of Employment**	**Address** (City, State/Country)	**Position Held** (Resident, Attending, Research Fellow, etc.)
06/2015	current (graduation 06/2019)	BCTH Israel Deaconess Medical Center	330 Brookline Ave Boston, MA 02215	Resident Physician
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Institution/Place of Employment**	**Address** (City, State/Country)	**Position Held** (Resident, Attending, Research Fellow, etc.)
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			
__/____	__/____			

PRINT NAME: Sara A. Mckinney DATE: 03/01/2019

1. **Opioid and Pain Management Training: (You must check one. See Instructions.)**
   - [X] I completed three (3) credits of Board-approved CPD/CME credit in effective pain management. (i.e., www.opioidprescribing.com)
   - [ ] I do not prescribe controlled substances (Schedules II – VI).

2. **Child Abuse or Neglect Recognition and Reporting Training: (You must check one. See Instructions.)**
   - [ ] 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 CPD/CME program in identifying and reporting child abuse and neglect.
   - [X] 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)

3. **Domestic and Sexual Violence Education and Training: (You must complete. See Instructions.)**
   - [X] 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

4. **MassHealth Enrollment Requirement: (You must check one. See Instructions.)**
   - [X] 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)

5. **Curriculum Vitae: (Required)**
   - [X] I have enclosed a current curriculum vitae (CV) with my application.

6. **Out-of-State Licensure:** List the state abbreviations where you currently or have ever had a full license:

   n/a

7. **Board Certification: (You must complete.)**
   a) Are you certified by the American Board of Medical Specialties (ABMS)? [ ] Yes [X] No
      If yes, list Board Certification(s): _____
   b) Are you certified by the American Board of Osteopathic Medicine (AOA)? [ ] Yes [X] No
      If yes, list Board Certification(s): _____

8. **Practice Specialty:** List the medical specialt(ies) that you practice. The medical specialties listed will be included on your Physician Profile to help consumers locate physicians in specific specialties. (If you are completing postgraduate training, list that specialty here):

   Obstetrics and gynecology

PRINT NAME: Sara A. McKinney DATE: 03/01/2019

Please answer the following questions.

9. Reason for requesting a Massachusetts medical license: received job offer as ob-gyn generalist at Beth Israel deaconess medical center

10. Name of anticipated practice location/facility: Beth Israel Deaconess medical Center

Address: 330 brookline ave. City: Boston, ma. 02215

11. Anticipated starting date in Massachusetts: 09/08/2019

Declaration and Signature

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

Signature of Applicant

03 / 01 / 2019
Month Day Year

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, Sara Ann McKinney
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature

12/27/2018
Date of Signature

McKinney, Sara, A
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

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

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

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

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

SECTION 3. SIGNATURE

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

NAME: Sara A. McKinney DATE: 1/2/2019

Harvard Medical School
Curriculum Vitae

Date Prepared:	**01 January 2019**
Name:	**Sara Ann McKinney**
Office Address:	**Beth Israel Deaconess Medical Center, East Campus, Kirstein Hall 3** **330 Brookline Avenue, Boston, MA 02115**
Home Address:	[redacted]
Work Phone:	**(617) 667-3736**
Work Email:	**Smckinn1@bidmc.harvard.edu**
Work FAX:	**(617) 667-0842**
Place of Birth:	[redacted]

Education:

06/2015	University of California Davis School of Medicine Doctor of Medicine
05/2010	Scripps College B.A. in Biology, Minor in history
09/2006-05/2007	Boston College

Postdoctoral Training:

06/2015-Present	Beth Israel Deaconess Medical Center Obstetrics and Gynecology Resident physician

Major Administrative Leadership Positions:

Local

03/2018-Present Co-Administrative Chief
Beth Israel Deaconess Medical Center / Harvard Medical School

- Provide leadership in the residency program and serve as liaison to the faculty.
- Lead in program and curricular improvements and enhance quality of program and life for residents.
- Coordinate resident schedules.

Regional

10/2015-06/2016 ACOG Junior Fellow Representative, District I
Beth Israel Deaconess Medical Center / Harvard Medical School
- Liaison between District / Section officers and the residency program, as well as medical students.

Committee Service:

Local

09/2018-Present Resident Information Systems Committee (RISC)
- Resident-led group focused on informational technology related quality improvement projects for the BIDMC online medical records

11/2018-Present Peer Mentor Nominee
- Provide support and mentorship to health care workers who are a part or witness an adverse event

04/2013-06/2015 Co-founder/director
Clinica Tepati Student Run Clinic: Women's Specialty Clinic
- Assisted in the establishment of a new women's specialty clinic.
- Organized and held clinic every 8 weeks.
- Established sustainability through grant funding and networking with other student run clinics.

09/2014-06/2015 Inter-Clinic Women's Health Collaboration Representative
University of California Davis School of Medicine
- Worked to maximize the coverage and care for female patients at the UC Davis student-run clinics.
- Assisted in standardizing referral protocols to local programs.

09/2013-03/2014 Alumni Interviewer
Scripps College
- Interviewed prospective high school senior students in the Sacramento area.
- Provided written interview report for each student regarding overall impression of candidate.

04/2012-06/2014 Outreach officer
Latino Medical Student Association
- Coordinated events with local community organizations.
- Organized medical student panels, health fairs, and an outreach day for underrepresented elementary school students.

09/2012-06/2014 Mock Multi-Mini Interviewer
Latino Medical Student Association
- Advised and prepared underrepresented students in the process or preparing to apply to medical school.

04/2011-06/2013 Co-director and Undergraduate Liaison
Clinical Tepati Student Run Clinic at the University of California Davis School of Medicine
- Coordinated the undergraduate class at UC Davis, which included recruiting speakers and leading discussions on a variety of health topics.
- Maintained clinic efficiency and assisted with clinic protocol.

National

04/2018 CREOG Resident Workshop
New Orleans, LA
- Workshop created to equip residents with the knowledge and skills necessary to serve as leaders and exemplary teachers for junior residents and medical students.

03/2016 ACOG Congressional Leadership Conference
Washington, DC
- Two-day intensive lobbying boot camp were participants lobbied members of congress on key legislative issues in women's health.

Professional Societies:

07/2018-Present	International Society for the Study of Vulvovaginal Disease
11/2016-Present	American Association of Laparoscopists
06/2015-Present	American College of Obstetrics and Gynecology
06/2011-06/2015	Latino Medical Student Association
09/2009-05/2010	Sigma Xi The Scientific Research Honor Society

Honors and Prizes:

05/2018 Fundamentals of Laparoscopic Surgery Certification
- Comprehensive web-based education module that includes a hands-on skills training component and assessment tool designed to teach the physiology, fundamental knowledge, and technical skills required in basic laparoscopic surgery.

05/2017 CREOG PGY2 Resident Award
Beth Israel Deaconess Medical Center, Harvard Medical School
- Awarded to PGY2 resident who demonstrated the best mentorship, teaching, and guidance to intern class.

05/2013 Medical Student of the Year
University of California Davis School of Medicine
- Awarded by UC Davis Clinica Tepati Student Run for commitment to clinical duties, advocating for underrepresented patients, and providing exceptional mentorship to students..

06/2012 Letter of Commendation in Clinical Neurology 420 Course
University of California Davis School of Medicine
- Awarded to students who received greater than 92.5% course grade.

12/2012 Letter of Commendation in Doctoring 1
University of California Davis School of Medicine Coordinated events with local community organizations.
- Awarded for excellent interviewing skills and demonstration of self-directed learning. 1 of 3 students to receive this honor in a class of 99 eligible students.

06/2011 UC Davis Alumni Association Scholarship Honoree
Scripps College
- Honor roll certification for Chicano/Latino students at the Claremont Colleges.

06/2007 Sr. Thea Bowman AHANA Honor Roll
Boston College
- Award conferred upon AHANA (African-American, Hispanic, Asian and Native American) students for achieving academic excellence.

12/2006 Deans Honor List
Boston College
- Awarded for academic excellence.

Report of Funded and Unfunded Projects

Past

04/2014 Primary investigator / Quality Improvement Project: Improving Chlamydia and Gonorrhea Screening prior to D&E when Indicated.
Retrospective cohort study of 500 charts for STI screening in women under the age of 25 undergoing D&E.

04/2013 Co-Investigator / Clinical Tepati Student Run Clinic: Needs Assessment and Quality Improvement
Responsible for developing and administering student run clinic surveys as well as interpreting data and assisting in the implementation of new protocol as suggested by survey findings.

06/2010 Co-Investigator / Understanding the Biological Mechanisms Affected by Bisphenol A Using S. cerevisiae as a Model Organism.
Screened 4,700 deletion strains of S. cerevisiae and then re-screened BPA sensitive strains in efforts to narrow down S. cerevisiae genes involved in the cellular mechanisms involved in BPA sensitivity.

Current

07/2018-Current Co-Investigator / Safety and Efficacy of Ablative Fractional 2940 nm Laser Treatment for Vulvar Lichen Sclerosus
This is a prospective study aimed to assess the safety and efficacy of ablative fractional 2940 nm laser treatment of vulvar lichen sclerosus. This study will assess physical and histological changes in subjects affected by vulvar lichen sclerosus and compare depth of disease before and after treatment as well as change in symptoms experienced by subjects.

11/2017-Present Co-Investigator / Culture shift in surgical approach and complication rates for hysterectomies at BIDMC after the addition of MIGS surgeons to faculty.
This is a retrospective cohort study from 2006-2016 of 2400 charts that seeks to quantify the change in gynecologic surgical culture by comparing rates of complications and surgical approach.

02/2016-Present Co-Investigator / Assessment of reliability between real-time versus delayed video-taped evaluation of cystoscopic skills
Prospective cohort study to determine if there is a difference between unblinded live observation versus recorded assessment of cystoscopic skills using validated cystoscopy OSATS and GRS checklists.

Report of Local Teaching and Training

Teaching of Students in Courses:

07/2018-Present OBGYN Harvard Medical School Clerkship Faculty
- Teach session *Contraception* for second and third year medical students.

2017-2018 OBGYN Harvard Medical School Clerkship Faculty
- Teach session *Examining the pregnant patient* for second and third year medical students.

02/2016-Present Harvard Medical School OBGYN Boot Camp Faculty
- Teach session on suturing and knot tying to fourth year medical students.

06/2012-12/2012 Biochemistry and genetics tutor
University of California Davis School of Medicine
- Provided first year medical students with assistance with first year curriculum.
- Reviewed lecture material through comprehensive power points and original practice questions.

10/2012 Latino Medical Student Association K-8 Outreach Day
University of California Davis School of Medicine
- Worked with 40 underrepresented 7th and 8th grade students from the Sacramento Unified School District's Spanish Language Academy.
- Promoted science education and helped in preparation of day activities.

06/2009-08/2009 English and Science Teaching Assistant
International Rescue Committee
- Assisted high school refugees by providing tutorial services for the subjects of English and General Science.

06/2007-08/2007 English as a Second Language Teaching Assistant
San Diego Catholic Charities
- Served as a teaching assistant in an English Language Training class for adult refugees.

Laboratory and Other Research Supervisory and Training Responsibilities:

09/2008-05/2009 General Chemistry Laboratory Teaching Assistant
Claremont Colleges
- Monitored students during actual experimental process.
- Provided one-on-one training on the proper utilization of equipment.
- Assisted with grading of assignments.

Publications

Peer-Reviewed publications in print or other media:

1. Chambers, M., **McKinney, S**. Healing Conduit: The Power of Human Touch. *Journal of the Student National Medical Association*. Summer 2014 Issue: 28-30, September 2014.

Reviews, chapters, monographs and editorials

1. Nezhat C, Falik R, **McKinney S**, King, LP Pathophysiology and management of urinary tract endometriosis *Nat Rev Urol* 2017 Jun; 14(6): 359-72
2. **McKinney S**, Young B. **Strip of the Month: Maternal Fever in Labor.** *NeoReviews* 2016;17;e674 DOI: 10.1542/neo.17-11-e674

Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings:

1. **McKinney S**, Li J, King LP, Lefevre R, Haviland MJ, Hur HC. Assessment and reliability between real-time versus delayed videotaped evaluation of cystoscopic skills. 2016. Presented as an oral presentation at the annual meeting of the AAGL, Orlando, FL.
2. **McKinney S**, Betancourt M, Miguel Romo-Martinez, Thabit C. Clinica Tepati Student Run Clinic: Needs Assessment and Quality Improvement. Presented at: The Western Regional Latino Medical Student Association 29th Annual Conference. San Diego, Ca. March 29-30, 2013.
3. **McKinney S**, Betancourt M, Romo-Martinez M, Thabit C. Clinica Tepati Student Run Clinic: Needs Assessment and Quality Improvement. Presented at: The National Hispanic Medical Association 17th Annual Conference. Washington, D.C, April 24-28, 2013.

Language and Skills

Fluent in Spanish.

Fundraising: Raised $8,870 for the OBGYN department at Beth Israel Deaconess Medical Center through the 2018 Boston Marathon Official Charity Program.

Interests

Long distance running

04/2018 Boston Marathon, Boston, Ma
12/2014 California International Marathon, Sacramento, CA
01/2014 Redding Marathon, Redding, CA
12/2013 California International Marathon, Sacramento, CA
10/2012 Nike Women's Marathon San Francisco, San Francisco, CA

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: McKINNEY (Last Name) SARA (First Name) A (Middle Initial) U.S. Social Security No: [redacted]

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

Name of Medical School: University of California Davis School of Medicine

Address: 4610 X Street City: Sacramento 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: Scripps College

Undergraduate School Address: 1030 Columbia Avenue, Claremont, CA 91711

Enrollment and Participation: Our records indicate that McKinney (Last Name) Sara (First Name) A (Middle Initial)
(print the applicant's name):

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
	07 / 25 / 11	06 / 15 / 12	06 / 23 / 14	06 / 11 / 15
	06 / 25 / 12	06 / 21 / 13	/ /	/ /
	06 / 24 / 13	06 / 20 / 14	/ /	/ /

Graduation Date (month/year): 06 / 2015

The applicant attended 165 **total weeks** *or* _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

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 six (6) years for international medical graduates?		[redacted]
2. 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")?		
3. Was the applicant ever placed on probation?		
4. Was the applicant ever disciplined or under investigation?		
5. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation if you answered "YES" to any of the above questions.

[redacted]

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: Rebecca Miller

Print Name: Rebecca Miller

Title: Registrar, UC Davis School of Medicine

Date: 4 / 2 / 2015 Telephone: (916) 734-4664

E-mail address: studentrecords@ucdmc.ucdavis.edu

ALS: Verified

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.

BFD

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 SARA A. MCKINNEY
(Student's Name)

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

from the University of California, Davis School of Medicine
(Name of Medical School)

and will receive the degree on 06 / 11 / 2015.

Signature of Certifying Official: Rebecca R Miller
(Original Signature is required – Stamps not accepted)

Printed Name: Rebecca R. Miller

Title: Registrar, UC Davis School of Medicine

Date: 04/21/2015

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 AD

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

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

PHOTOGRAPH

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blic.

Signature of applicant

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

Signature of Notary

01.17.2025
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

SARA A. MCKINNEY, M.D.
(name of applicant)

for 3.5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of Certifying Physician

247979 — License Number
MA — State

MONICA L. MENDIOLA, MD
Type or print name clearly

Address: 330 BROOKLINE AVE.

City: BOSTON State: MA Zip: 02215

Telephone: (617) 667-2285

Date: 12 / 27 / 18

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

Seal Verified DATE: 1-9-19 INITIALS: AD

Sealed Envelope

Initials AD

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

Applicant's Signature: _____ Date: 12/27/2018

Print or Type Name: Sara Ann McKinney

Name and Address of Institution: Beth Israel Deaconess Medical Center
330 Brookline Ave, Boston MA 02215

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**

Name of Institution: BETH ISRAEL DEACONESS MEDICAL CENTER

Name of Institution, if different when applicant attended: _____

Verification for: SARA A. McKINNEY
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
INTERNSHIP	1	OB/GYN	06/15/15	06/13/16	YES	ACGME
~~RESIDENCY~~	~~2 - A~~	~~OB/GYN~~	~~06/19/16~~	~~06/14/19~~	IN PROGRESS	ACGME
RESIDENCY	2	OB/GYN	06/20/16	06/18/17	YES	ACGME
RESIDENCY	3	OB/GYN	06/19/17	06/17/18	YES	ACGME
RESIDENCY	4	OB/GYN	06/19/18	06/14/19	IN PROGRESS	ACGME

MM

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

MONICA MENDIOLA, MD. 3.13.2019

APPLICANT'S NAME: Sara A. McKinney, MD

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 enclose an explanation.**

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?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____

Print Name: Monica L. Mendiola, MD

Academic Title: Residency Program Director

Telephone: (617) 667-2985 Today's Date: 12/27/18

E-mail address: mmendial@bidmc.harvard.edu

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

Seal Verified
DATE: 1-9-19
INITIALS: AD

PRINT NAME: Sara A. McKinney DATE: 12/27/2018

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide a detailed explanation and arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the underlying occurrence or action. Documents should be sent directly to you in a sealed envelope.

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

PRINT NAME: Sara A. McKinney DATE: 12/27/2018

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

PRINT NAME: Sara A. McKinney DATE: 12/27/2018

CONFIDENTIAL INFORMATION

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

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

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

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

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

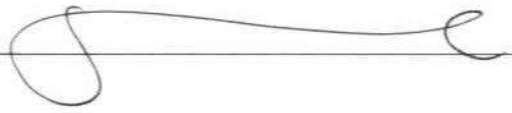
If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Sara A. McKinney DATE: 12/27/2018

CERTIFICATIONS

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

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

Applicant's Signature:  Date: 12/27/2018

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sara A McKinney, M.D. **License No.:** 278195

Current Status: Active **License Expiration Date:** 9/3/2019

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address: [redacted]

Home Address:

Business Address: 330 Brookline Ave
East Campus, Kirstein 3
Boston
Massachusetts - 02215
United States of America
(617) 667-3736

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

4) **Fax Number:** (617) 667-7493

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
[redacted]		

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

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

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

WorkSite	Location
Beth Israel Deaconess Medical Center	

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

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Other

Graduated from residency 06/14/2019. My start date is 09/09/2019 at Beth Israel Deaconess Medical Center. My insurance through CRICO begins at that time. I am not involved with direct or indirect patient care in Massachusetts until then.

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

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

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

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

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

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

Physician Name: Sara A McKinney, M.D. **License No.:** 278195

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?** [redacted]

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

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

23) Do you have a medical or physical condition that currently impairs your ability to practice medicine?

[redacted]

24) Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?

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: Sara A McKinney, M.D. **License No.:** 278195

☒ **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sara A McKinney, M.D. **License No.:** 278195

Current Status: Active **License Expiration Date:** 9/3/2021

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address: [redacted]

Home Address: [redacted]

Business Address: 330 Brookline Ave
East Campus, Kirstein 3
Boston
Massachusetts - 02215
United States of America
(617) 667-3736

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

4) **Fax Number:** (617) 667-7493

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
[redacted]		

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

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

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

WorkSite	Location
Beth Israel Deaconess Medical Center	

Physician Name: Sara A McKinney, M.D. **License No.:** 278195

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 24 hrs/wk
b) outpatient care 24 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	09/09/2019	12/31/2021	Claims made with tail coverage

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

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

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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?

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Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
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b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

Physician Name: Sara A McKinney, M.D. **License No.:** 278195

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

23) Do you have a medical or physical condition that currently impairs your ability to practice medicine?

[redacted]

24) Have you engaged in the use of any chemical substance(s) with the result that your ability to practice medicine is currently impaired?

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: Sara A McKinney, M.D. **License No.:** 278195

☒ **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.**