RECEIVED
OCT 19 2020
Board of Registration in Medicine

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	

PERSONAL INFORMATION

1. Legal Name	Last: Cashman	First: Casandra	Middle: Miller	Suffix:
2. Other Name(s) List other names that appear on your application documents (medical education, exams, etc.)	Last: [redacted]	First: [redacted]	Middle:	Suffix:
3. Degree Type	☑ M.D. ☐ D.O. ☐ Other degree: ______			
4. Social Security Number	[redacted]	**5. Gender**	☐ Male ☑ Female	
6. NPI Number	1164656013			
7. Date of Birth	[redacted] (Month Day Year)	**8. Place of Birth**	City/State: [redacted]	Country if not USA:
9. Mailing Address	Number and Street: [redacted]			
This address will be used for correspondence	City: [redacted]	State/Province/Territory: [redacted]	Zip (or postal) Code: [redacted]	
10. Home Address	Number and Street: [redacted]			
	City: [redacted]	State/Province/Territory: [redacted]	Zip (or postal) Code: [redacted]	
11. Business Address	Number and Street: 1125 Mission st. 2nd fl.			
	City: San Francisco	State/Province/Territory: California	Zip (or postal) Code: 94103	
12. Telephone Numbers	Home #:	Business #:	Cell #: 502-759-8027	
13. Email Address Will be used for correspondence	[redacted]			

Date Received: 10/19/2020

Check #: 1157

Check Amount: $ 600.00

Initials: RF

PRINT NAME: CASANDRA CASHMAN

Questions #14 – 16 are optional. This information will assist the Board in processing your application.

14. **Reason for requesting a Massachusetts medical license:** providing services pertaining to family planning, women's sexual health, and STI testing via telemedicine platform

15. **Name of anticipated practice location/facility:** practice will be via telemedicine

Address: 1125 Mission st. 2nd fl. City: San Francisco, CA. 94193

16. **Anticipated starting date in Massachusetts:** 10 01 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.

IN (Active) GA (Active) C.C 1/13/21

FL (voluntarily relinquished)

MI (lapsed)

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.**

Family Medicine

ABMS/AOA BOARD CERTIFICATION

19. **Are you certified by the American Board of Medical Specialties (ABMS)?** ☑ Yes ☐ No

If "Yes", list Board Certification(s): ABFM: Cert # (1001829815): Issued: 7/1/2012 - Clinically Active

20. **Are you certified by the American Board of Osteopathic Medicine (AOA)?** ☐ Yes ☑ No

If "Yes", list Board Certification(s):

PRINT NAME: CASANDRA MILLER CASHMAN

EXAMINATION HISTORY

Please note below each medical licensure examination you have taken.

NOTE: Your official examination scores will be included in your FCVS Physician Profile.

***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)	Failed (F)
USMLE Step I	1	☑ P	☐ F
USMLE Step II CK	1	☑ P	☐ F
USMLE Step II CS	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
COMLEX Level 1		☐ P	☐ F
COMLEX Level 2 CE		☐ P	☐ F
COMLEX Level 2 PE		☐ P	☐ F
COMLEX Level 3		☐ P	☐ F
MCCQE – Part I		☐ P	☐ F
MCCQE – Part II		☐ P	☐ F
State Board Exam	State of Examination:	☐ P	☐ F

PRINT NAME: CASANDRA MILLER CASHMAN

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)
Wells College	BA	2000 to 2003
	City	**State/Country**
	Aurora	NY / USA

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
University of Louisville School of Medicine	MD
Street	**City, State**
500 S Preston St	Louisville, KY. 40202

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

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

PRINT NAME: CASANDRA MILLER CASHMAN

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
05/2009 (Month Year)		**Medical School Graduation Date** *(start timeline from this date)*		
06/2009	07/2009	NONE	moving and orientation for Residency	Daytona Beach, FL.
07/2009	06/2012	Resident	Halifax Medical Center	Daytona Beach, FL.
07/2012	06/2013	Fellow	University of Michigan	Ann Arbor, MI.
07/2013	Present	Assistant Director, Clinical Faculty	Community East FM Residency	Indianapolis, IN.
07/2013	Present	Contract Position	Planned Parenthood	Indianapolis, IN.
1/2020	Present	Director of Program Development	RHEDI	New York, NY (remote)
8/2020	Present	Physician	NURX	San Francisco, CA (remote)

PRINT NAME: CASANDRA MILLER CASHMAN

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.)		
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		
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: CASANDRA CASHMAN

	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?		
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: CASANDRA MILLER CASHMAN

MEDICAL MALPRACTICE HISTORY QUESTION			
You <u>must</u> 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.		

CRIMINAL HISTORY QUESTION			
You <u>must</u> 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. <u>Expunged/Sealed Offenses</u>: 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.		

PRINT NAME: CASANDRA MILLER CASHMAN

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?		
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.

Casandra Cashman, M.D., FAAFP

EMPLOYMENT & APPOINTMENTS

Nurx
Reproductive Health via Telemedicine
Physician, August 2020- Present — Remote

Community Health Network — Indianapolis, Indiana
Family Medicine Residency Program
Women's Health Faculty, June 2019- Present
Assistant Director, December 2013- June 2019
Clinical Faculty, July 2013- December 2013

- getLARC grant coordinator
  - May 2014-April 2017
  - Development of LARC educational program for residents, creation of LARC clinic providing contraception to un/underinsured patients, and lead physician for postpartum LARC implementation at Community East
- Reproductive Health Access Project Miscarriage Care Initiative clinical champion, September 2017-present
- Centering Pregnancy certified facilitator
- Obstetrics track developer & coordinator, GYN procedure clinic developer & lead physician
- Providing adult inpatient, newborn nursery, obstetrical, & outpatient (including colposcopy, LEEP, and uterine aspiration) services
- MedCheck urgent care (intermittent basis only)

Center of Hope Sexual Assault Forensic Nursing Program — Indianapolis, Indiana
Medical Director
February 2017-Present

RHEDI (Reproductive Health Education in Family Medicine)
Montefiore Medical Center — New York, New York
Director of Program Development
January 2020-Present

Planned Parenthood of Indiana & Kentucky — Indianapolis, Indiana
Contract Physician
July 2013-Present

Indiana University School of Medicine — Indianapolis, Indiana
Volunteer Clinical Assistant Professor of Family Medicine
March 2014-Present

Volunteer Clinical Assistant Professor of Obstetrics & Gynecology
October 2016-Present

EDUCATION & TRAINING

Community Health Network Physician Leadership Academy
Small group, application only, yearlong intensive course for physicians in leadership positions
September 2019-Present

Physicians for Reproductive Health
Leadership Training Academy Fellow
July 2013-June 2014

University of Michigan Ann Arbor, Michigan
Women's Health Fellow, Department of Obstetrics & Gynecology
Clinical Lecturer, Department of Family Medicine
July 2012-June 2013
- Faculty Development Institute participant
- Visiting Professor at Shizuoka Family Medicine Residency, Shizuoka, Japan

Halifax Medical Center Daytona Beach, Florida
Family Medicine Residency with Women's Health Area of Concentration
July 2009-June 2012
- Introduction to OB/GYN Ultrasound at Gulfcoast Ultrasound Institute

University of Louisville School of Medicine Louisville, Kentucky
Doctor of Medicine, May 2009

Wells College Aurora, New York
Bachelor of Arts, *magna cum laude*
Psychology with a minor in Music, May 2003

LICENSURE & CERTIFICATIONS

ALSO: Advanced Life Support in Obstetrics Advisory Faculty, September 2015
ACLS: Advanced Cardiac Life Support Provider, June 2018
NRP: Neonatal Resuscitation Protocol Provider, February 2018
Fellow, American Academy of Family Physicians, January 2015
Diplomate #1001829815, American Board of Family Medicine, July 2012
Active and unrestricted Indiana medical license

PRESENTATIONS & PUBLICATIONS

Identifying Violence and Abuse During Telehealth Visits
- Community Health Network Continuing Medical Education, June 2020

Expanding Care for Early Pregnancy Loss in Family Medicine Settings: The Miscarriage Care Initiative (Lead Panelist)
- Family Medicine Midwest, Naperville, Illinois, November 2019
- Cashman, C., Wells, T., Riker, L.

Resident Satisfaction with Clinic Experiences in an FQHC and a Hospital-owned Practice (poster)

- Cashman, C., et al
- Community Health Network Multidisciplinary Research Symposium, Indianapolis, May 2019

Contraception; Implications for Psychiatric Practice

- Psychiatry Grand Rounds, Community Hospital Network, December 2018

Cashman, C. et al. Contraception. Essential Evidence Plus. John Wiley & Sons, Inc. Available online at: http://www.essentialevidenceplus.com.

LARC: Who, What, When Where, Why and How to Get it for Women Who Can't Afford It

- Indiana Academy of Family Physicians Research Day, CME Session, Indianapolis, March 2018

Adequately Providing Our Patients with Birth Control Options when Taking Teratogenic Medications (poster)

- McKay, L., Sharaya, N., **Cashman, C.**
- Society of Teachers of Family Medicine, Practice Improvement Conference, Louisville, November 2017
- Indiana Academy of Family Physicians Research Day, Indianapolis, May 2018
- Community Health Network Multidisciplinary Research Symposium, Indianapolis, March 2018

LARC: Immediate Postpartum Placement and Care (poster)

- Wire, A., **Cashman, C.**
- Community Health Network Nursing Symposium, September 2017

Preterm Labor & Delivery

- Halifax Medical Center, April 2017

Postpartum Long-Acting Reversible Contraception

- Community Hospital East, Nursing Grand Rounds, April 2017

Indiana Perinatal Quality Improvement Committee "LARC Toolkit" author, 2016-2018

LARC: Who, What, When, Where, Why and How To Get It For Women Who Can't Afford It

- Indiana University Center of Excellence in Women's Heath, Women of INfluence Annual Symposium 2016, Indianapolis, September 2016

Group Prenatal Care: A Comparison of Select Measures to National and Local Norms (poster)

- Bachman, K., Agee, S., Clark, J., **Cashman, C.**
- Indiana Academy of Family Physicians Research Day, Indianapolis, May 2016
- AAFP Family Centered Maternity Care, Madison, WI, August 2016

Long-Acting Reversible Contraceptive Methods to Reduce Infant Morbidity & Mortality (poster)

- American Medical Women's Association, Annual Meeting, Miami, Florida, March 2016

Increasing the use of Long-Acting Reversible Contraceptives in the Family Medicine Residency Clinic (poster)

- Society of Teachers of Family Medicine, Practice Improvement Conference, Dallas, Texas, December 2015

Long-Acting Reversible Contraception to Reduce Perinatal Morbidity (poster)

- Labor of Love Infant Mortality Summit, Indianapolis, Indiana, November 2015

Reproductive Coercion and Improving Contraceptive Counseling

- Domestic Violence Network, Indianapolis, Indiana, August 2015

Resident Lectures: PCOS, Psychiatric Emergencies, Colposcopy, Choosing & Changing Oral Contraceptives, Vulvar Dermatology, Substance Withdrawal, Exercise Prescription, Hematuria

- Community Health Network East Family Medicine Residency Program

Team Time Small Group Learning Modules on Contraception (Half day, 4-6 per year)

- Community Health Network East Family Medicine Residency Program, 2013-2019

Noelle Birth Simulator and Clinical Cases

- Community Health Network East Family Medicine Residency Program, Intersession 2013, 2015, 2016

The Postpartum Office Visit
Ovarian Masses
Miscarriage Management

- Shizuoka Family Medicine Residency Program, Shizuoka, Japan, May and June 2012

Chlamydial Sexually Transmitted Infection

- The 5-Minute Clinical Consult 2014-20 editions

Ovarian Torsion

- The 5-Minute Clinical Consult 2014-17 editions

Reproductive Coercion

- University of Michigan, Department of Family Medicine Grand Rounds, May 2013

Abnormal Uterine Bleeding at Perimenopause and Beyond

- University of Michigan Family Medicine Residency Program, November 2012

Glomus Tumor of the Breast: A Case Report

- Consultant, September 2012

MMR Vaccination and Pregnancy

- Halifax Medical Center, May 2012

Adolescent Contraception Update

- "Primary Care Conference" Halifax Medical Center, February 2012

Hypoglycemia in the Hospitalized Patient; Morbidity & Mortality

- Halifax Medical Center, October 2011

Identification and Reduction of Reproductive Coercion; Improving Contraceptive Counseling

- Halifax Medical Center, August 2011

Insomnia in the Primary Care Setting
- Grand Rounds, Halifax Medical Center, April 2011

Pelvic Organ Prolapse Quantification: Graphical Modeling (with Drs. S.B. Tate & L.J. Goldsmith)
- University of Louisville School of Medicine & School of Pubic Health and Information Sciences, 2006

HONORS & AWARDS

Gold "Difference Makers" Award- *for innovative patient care regarding miscarriage in the family medicine office setting*
Community Health Network, July 2019

Adequately Providing Our Patients with Birth Control Options when Taking Teratogenic Medications (poster)

McKay, L., Sharaya, N., **Cashman, C.**
Indiana Academy of Family Physicians Research Day, Third-Place Poster, May 2018

Group Prenatal Care: A Comparison of Select Measures to National and Local Norms (poster)

Bachman, K., Agee, S., Clark, J., **Cashman, C.**
Indiana Academy of Family Physicians Research Day, Second-Place Poster, May 2016

North American Menopause Society
Pfizer Medical Resident & Fellow Reporting Award, July 2012

First-Time Student Attendee Award
American Academy of Family Physicians National Conference, July 2008

Joseph Collins Scholarship Recipient
University of Louisville School of Medicine, 2006-2008

LEADERSHIP & SERVICE

Pregnancy at a Time that is Healthy and Happy for You (PATH4U)
Provider Advisory Board
Indiana University — Indianapolis, Indiana

Indiana Cluster Leader
Reproductive Health Access Project — Indianapolis, Indiana

JCC Indianapolis Early Childhood Education Committee
Volunteer Member, 2016-2019 — Indianapolis, Indiana

Family Medicine Midwest Educational Program Committee
Submissions Reviewer, 2016-18 — Indianapolis, Indiana

Indiana Perinatal Quality Improvement Committee, LARC Subcommittee Member
Member, May 2016- Present — Indianapolis, Indiana

Pre-Medical Advisory Physician Volunteer
Wells College, September 2012- 2018 — Aurora, New York

Noon Conference Coordinator
Halifax Medical Center, July 2010-June 2011 — Daytona Beach, Florida

Reproductive Freedom Project Board Member
American Civil Liberties Union, Spring 2008- May 2009 — Louisville, Kentucky

Founding Chair
Medical Students for Choice, ULSOM, August 2007- May 2009 — Louisville, Kentucky

Reproductive Health Externship
Medical Students for Choice, Fall 2006-Spring 2007 — Louisville, Kentucky

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LIABILITY CARRIER REQUEST FORM

Applicant Print Name: Casandra Miller Cashman

APPLICANT INSTRUCTIONS: **Print name above**. In **chronological order**, list your liability carriers covering the **past 10 years that you have held a full license in the U.S. or Canada**. Only include liability carriers from postgraduate training if it was within the past 10 years and you held a full license at that time. Send a copy of this form to each carrier in order to request a claims history report. Send the original form to the Board with your application.
This form is not required if you have never held a full license in the U.S. or Canada.

Liability Carrier	Veritas Insurance Corporation (University of Michigan)		
Dates of Coverage	From: 07 / 2012 To: 6/2013	**Policy Number**	VMPL-2012
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2013 To: 01 / 2014	**Policy Number**	NYC-009739453-21
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2014 To: 01 / 2015	**Policy Number**	NYC-009739453-19
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2015 To: 01/2016	**Policy Number**	NYC-009739453-17
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2016 To: 01 / 2017	**Policy Number**	NYC-009739453-15

LIABILITY CARRIER INSTRUCTIONS: Please provide the following documentation directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician's name in the subject line of the email.

Claims History Report/Loss Run Report: Please provide a claims history report on letterhead, which includes:

1. Policy number
2. Dates of policy coverage;
3. If your company's name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
   a. the name/initials of the claimant(s);
   b. nature and date of claim(s);
   c. whether the claim is pending or closed. If closed, final disposition; and
   d. amounts paid on the applicant's behalf, if any.

Additional Claim Documentation: If the applicant has a claims history, please provide copies of the following:

1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.

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Applicant Print Name: Casandra Miller Cashman

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This form is not required if you have never held a full license in the U.S. or Canada.

Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2017 To: 01 / 2018	**Policy Number**	NYC-009739453-13
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2018 To: 01 / 2019	**Policy Number**	NYC-009739453-11
Liability Carrier	National Union Fire Ins. Co. (Planned Parenthood of Indiana and Kentucky)		
Dates of Coverage	From: 01 / 2019 To: 05 / 2020	**Policy Number**	NYC-009739453-09
Liability Carrier	Hays Companies Inc (Underwriters at Lloyd's, London) - (Nurx)		
Dates of Coverage	From: 03 / 2020 To: 03 / 2021	**Policy Number**	W26523200201
Liability Carrier			
Dates of Coverage	From: ____ ____ To: ____ ____	**Policy Number**	

LIABILITY CARRIER INSTRUCTIONS: Please provide the following documentation directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician's name in the subject line of the email.

Claims History Report/Loss Run Report: Please provide a claims history report on letterhead, which includes:

1. Policy number
2. Dates of policy coverage;
3. If your company's name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
   a. the name/initials of the claimant(s);
   b. nature and date of claim(s);
   c. whether the claim is pending or closed. If closed, final disposition; and
   d. amounts paid on the applicant's behalf, if any.

Additional Claim Documentation: If the applicant has a claims history, please provide copies of the following:

1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.

Sealed Envelope

Initials: MJ

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

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 or Canada. 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:

CASANDRA MILLER CASHMAN
(print name of applicant)

for 7 **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: [signature] **DATE:** 8/27/20

Print Name: Carol Dellinger MD

License Number: 01056172A **State:** IN

Address

City: **State** **Zip**

Email:

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

October 15, 2020

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

RE: License Certification for Casandra Miller Cashman

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME107804
ORIGINAL CERTIFICATION:	07/23/2010
EXPIRATION DATE:	01/31/2014
CURRENT STATUS OF LICENSE:	VOLUNTARY RELINQUISHMENT
AGENCY ACTION:	

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595.

Georgia Composite Medical Board

Executive Director
LaSharn Hughes, MBA

Deputy Director
Lisa R. Norris, MPH

Chairperson
Gretchen Collins, MD

Vice Chairperson
Barby Simmons, DO

2 Peachtree Street, NW • 6th Floor • Atlanta, Georgia 30303 • (404) 656-3913
www.medicalboard.georgia.gov

October 15, 2020

RE: **Casandra Cashman**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a **Physician** license by the Georgia Medical Board.

It is further certified that:

The license number is **86940** and was issued on **September 15, 2020**

The current license status is **Active**

The license expiration date is **January 31, 2022**.

Certified this day Thursday, 15 October, 2020

Sincerely,

LaSharn Hughes
Executive Director

LLH/

STATE OF INDIANA

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: Casandra Cashman

I, Deborah J. Frye, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature.

To verify the authenticity of the digital certification as of the date and time stamp below, go to
https://secure.in.gov/apps/pla/search/verify/
and use our free web service. Simply browse to the location you saved the secure PDF document sent to you and upload to validate. You may also verify the authenticity in Adobe by ensuring the 'Certified by State of Indiana' blue ribbon displays at the top of the PDF.

Deborah J. Frye

Deborah J. Frye, Executive Director
Tue Aug 18 02:40:45 PM EST 2020

STATE OF INDIANA

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information	
Name:	Casandra Cashman
Address:	Community Group Family Medicine 10122 E. 10th Street, Suite 100 Indianapolis, IN 46229
Date of Birth:	[redacted]

License Information	
Number Issued:	01072626A
License Type:	Physician
Status:	Active
Issue date:	05/16/2013
Expiration Date:	10/31/2021
Obtained By:	Application

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For disciplinary action information, please visit our License Search & Verify service at www.in.gov/pla/3119.htm. Disciplinary action will either show under Previous Action or Violations. For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at http://www.in.gov/pla/boards.htm.

Digitally Certified on: Tue Aug 18 02:40:45 PM EST 2020

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

Sealed
Envelope
Initials: MF

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 10/30/2020

NAME: **Casandra Miller Cashman**
ADDRESS: Dept of Family Medicine
L2003 Women's Health
1500 E Medical Center Dr
Ann Arbor, MI 481095239

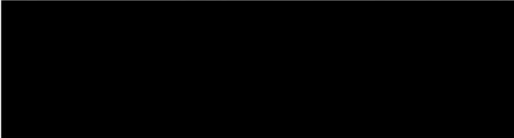
BIRTH YEAR:
STATUS: Lapsed

LICENSE TYPE: Medical Doctor License

ORIGINAL DATE: 01/17/2012
EXPIRATION DATE: 01/31/2016
SPECIALTY: None

LICENSE NUMBER: 4301099902
OBTAINED BY: Examination

EXAM DATE	EXAM TYPE	EXAM RESULTS
03/19/2010	USMLE	P



RECEIVED
NOV 5 2020
Board of Registration in Medicine

Brian DeBano, Division Director
Bureau of Professional Licensing
Licensing Division
(517) 241-0199

PRINT NAME: CASANDRA MILLER CASHMAN

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.,) ☑ 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"). ☐ 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.
56.	**MassHealth Enrollment Requirement: (You must check one.)** ☑ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider. (Nonbilling application:) ☐ 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: CASANDRA MILLER CASHMAN

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:

- [x] 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: ______ 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:

- [x] **I confirm I have read and agree to comply with these statutory and regulatory requirements.**

MA

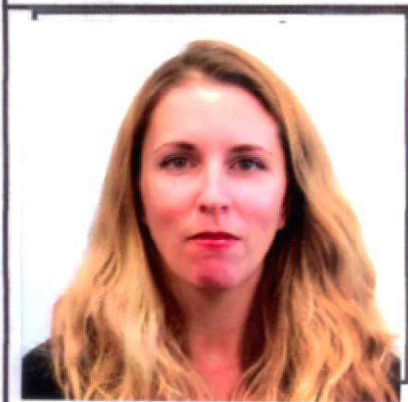
DECLARATION OF APPLICANT

I, Casandra Miller Cashman :
(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: [signature] **DATE:** 8.25-20

PHOTOGRAPH



SIGNATURE OF APPLICANT: [signature]

(Sign in the presence of a notary)

NOTARY SECTION

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

On this 25 day of August, 2020, before me, the undersigned notary public, personally appeared Casandra Miller Cashman (name of document signer), proved to me through satisfactory evidence of identification, which were Drivers Lisence, 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]
Signature of Notary Public

11/20/2024
Commission Expires On

NOTARY SEAL

MICHAEL J CONNORS
NOTARY PUBLIC - SEAL
STATE OF INDIANA
COMMISSION NUMBER 598070
MY COMMISSION EXPIRES NOV. 20, 2024

Seal Verified
DATE: 10.20.20
INITIALS: MJ

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Casandra M Cashman, M.D. **License No.:** 286323

Current Status: Active **License Expiration Date:** 1/21/2022

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address: 548 Market St, Suite 94061
San Francisco
California - 94104
United States of America
(800) 321-6879

3) **Email Address**

4) **Fax Number:**

5) **Specialties**
Family Medicine

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
Alabama
Georgia
Illinois
Indiana
Kentucky

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
	None Reported

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.

Not involved with direct or indirect patient care in Massachusetts.

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

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

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

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

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

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

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

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

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

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

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

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

25) Alzheimer's Training Requirement

I have completed the required Alzheimer's and Dementia Training.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Casandra M Cashman, M.D. **License No.:** 286323

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.

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

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

RECEIVED

FEB 08 2023

Board of Registration in Medicine

Commonwealth of Massachusetts

Board of Registration in Medicine

178 Albion Street, Suite 330, Wakefield, MA 01880

Telephone (781) 876-8230

www.mass.gov/massmedboard

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application, or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications, and information from health care entities.

"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named **below:"**

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Medical Board of Mississippi

ADDRESS: 1867 Crane Ridge Drive, Suite 200-B

CITY: Jackson STATE: MS ZIP: 39216

PHYSICIAN'S NAME: Casandra Cashman

BUSINESS ADDRESS: 27 E 28th St 12th Floor

CITY: New York STATE: NY ZIP: 10016

EMAIL ADDRESS: certification@msbml.ms.gov

MASSACHUSETTS LICENSE NUMBER: 286323

SIGNATURE OF PHYSICIAN: Casandra Cashman

Signed under the penalties of perjury

DATE: 2/1/2023

Date Received: 2/8/23

Check #: 5109

Check Amount: $ 20.00

Initials: RF

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

RECEIVED

FEB 08 2023

Board of Registration in Medicine

Commonwealth of Massachusetts
Board of Registration in Medicine
178 Albion Street, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

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"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named **below:"**

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Medical Board of Tennessee

ADDRESS: 665 Mainstream Drive

CITY: Nashville STATE: TN ZIP: 37243

PHYSICIAN'S NAME: Casandra Cashman

BUSINESS ADDRESS: 27 E 28th St 12th Floor

CITY: New York STATE: NY ZIP: 10016

EMAIL ADDRESS: Medical.Health@tn.gov

MASSACHUSETTS LICENSE NUMBER: 286323

SIGNATURE OF PHYSICIAN: Casandra Cashman
Signed under the penalties of perjury

DATE: 2/6/2023

#5109

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

Rev. 12/2021

Rcvd: 3/31/23
#: 1070
Check Amount: $ 10.50
Initials: CW

Commonwealth of Massachusetts
Board of Registration in Medicine
178 Albion Street, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

RECEIVED
MAR 31 2023
Board of Registration in Medicine

WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license applicati~~on, renewal~~ Casandra application, or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications, and information from health care entities.

***"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named* below:"**

(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Pennsylvannia Medical Bord

ADDRESS: P.O. Box 2649

CITY: Harrisburg STATE: PA ZIP: 17105

PHYSICIAN'S NAME: Casandra Cashman

BUSINESS ADDRESS 27 E 28th St 12th Floor

CITY: New York STATE: NY ZIP: 10016

EMAIL ADDRESS: ST-MEDICINE@PA.GOV

MASSACHUSETTS LICENSE NUMBER: 286323

SIGNATURE OF PHYSICIAN: Casandra Cashman
Signed under the penalties of perjury

Date: 3/20/2023

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