Print Form

Application #: 237548 B.H. 5/30
ch: 0250325212

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 - www.massmedboard.org

MAY 28 2008
Board of Registration in Medicine

INITIAL LIMITED LICENSE APPLICATION

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

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

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement To Be Completed by Applicant

1-A. Name: (Last) Davidson (First) Autumn (MI) S

1-B. Other Name(s): _____

	YES	NO
1) Have you ever been known under a different name or combination of names?		[redacted]
2) Have you ever been licensed under a different name?		
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?		

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

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

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

E-mail Address [redacted]

4. Sex: ☐ Male ☒ Female 5. Social Security Number: [redacted]

6. Name of Massachusetts Training Program: UMass Memorial Health Care

55 Lake Ave. North Worcester, MA 01655
Street Address (City)

05/18/08 SI

PRINT NAME Autumn Davidson

7. Name of premedical school(s): Columbia University, Portland State Uni, s
Location: New York, NY, Portland, OR
(City, State, Country)

8. Name of medical school(s): Brown Medical School
Location: Providence, RI
(City, State, Country)

Date of Graduation: 5 / 25 / 08 Degree: ☒ M. D. ☐ D. O. Other (specify)_____
(Month) (Day) (Year)

(See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? ☒ No ☐ Yes
Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____

Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/__ Specialty: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *ever* had a license to practice medicine (include residency training licenses).
_____ ☐(Full) _____ ☐ (Full) _____ ☐ (Full) _____ ☐(Limited) _____ ☐ (Limited)

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

USMLE ☒ Step 1 ☐ Step 2 (CK) ☐ Step 2 (CS) ☐ Step 3

NBME ☐ Part 1 ☐ Part II ☐ Part III ☐ COMLEX ☐ Level 1 ☐ Level 2 ☐ LMCC

	YES	NO
12-A. If you are a USMG, have you taken more than 4 years to complete medical school? Please see enclosed explanation		[redacted]
12-B. If you are an IMG, have you taken more than 6 years to complete medical school? If yes, you must provide additional information. (See instructions).		
13. Has *more than one year* passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? If yes, you must provide additional information with your curriculum vitae and include the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)		

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

This certifies that Autumn S. Davidson has been appointed
(Name of Applicant)

to the position of ☒ Intern ☐ Resident ☐ Fellow

in the specialty of Ob-Gyn as a PGY 1

Department: Ob-Gyn Subspeciality: _____

at Umass Memorial Medical Center
(Name of Healthcare Facility)

beginning 7/1/08 (Month/Day/Year) to anticipated completion of training: 7/1/2012 (Month/Day/Year)

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

Designated Official's Signature: Marilyn P. Leeds

Type or Print Name: Marilyn Leeds

Official Title: Administrative Director Graduate Medical Education

Date: 5/27/2008 Telephone Number: 508-856-2903

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

PRINT NAME: Autumn Davidson

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

	YES	NO
14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training? **If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.**		[redacted]
15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16-A. Have you ever been terminated or granted a leave of absence, regardless of the reason, by a medical school or a postgraduate training program?		
16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program? **If you answered "yes" to 16-A or B, you must provide an explanation and request a letter of explanation from your medical school or postgraduate training program.**		
17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		

		YES	NO
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).		
22.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you ever voluntarily relinquished any medical staff membership, medical staff privileges or medical staff status?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, whic is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

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PRINT NAME: Autumn Davidson

CONFIDENTIAL MEDICAL INFORMATION

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

		YES	NO
30.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or function as a physician?		[redacted]
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

CERTIFICATIONS:

- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license application and all its accompanying instructions, forms and statements, and to the best of my knowledge, and belief, the information contained herein is true, correct and complete. As an applicant for a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Applicant's Signature: Autumn Davidson **Date:** 4/10/08

COMMONWEALTH OF MASSACHUSETTS–BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 (617) 654-9810

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Autumn S. Davidson
(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
560 Harrison Avenue, Boston, MA 02118
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.

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

4/10/08
Date of Signature

Davidson, Autumn, S
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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AuTumn Shoshauna Davidson
[redacted]

Present Mailing Address
[redacted]

Permanent Mailing Address
[redacted]

Medical Education
Brown Medical School, Providence, RI
08/2005 -
M.D., 05/2008

Dartmouth/Brown Combined Medical Degree Program, United States Of America
08/2003 -
M.D., 05/2008

Education
Undergraduate - Portland State University, Portland, OR
Post-Baccalaureate
01/2001 - 06/2002

Undergraduate - University Of Oregon, Eugene, OR
Post-Baccalaureate
09/2000 - 12/2000

Undergraduate - Columbia University, New York, NY
Political Science
09/1996 - 05/2000
B.A., 05/2000

Membership and Honorary/Professional Societies
NIH/Fogarty Ellison International Clinical Research Scholar, St. Petersburg, Russia 2006-2007

Brown International Health Institute Foreign Studies Fellow, Phnom Penh, Cambodia, 2006

American Medical Women's Association Overseas Assistance Grant recipient, 2006

Brown Medical School Grant recipient, poster presentation, XVI International AIDS conference, Toronto, 2006

Finalist, Young Investigator's Award, Rhode Island 14th Annual Hospital Research Celebration, 2006
American Medical Students Association
Physicians for Human Rights
Medical Students For Choice
American Medical Women's Association
Rhode Island Women's Association
Women and Infants Hospital Ethics Committee

Examinations
USMLE Step 1 06/2005

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Work Experience

07/2004 - 08/2004 **Average Hours/Week:** 40
Doctors Of The World, Romania
Intern
Performed field visits to Roma Communities around Bucharest
Conducted interviews with Roma Community leaders to assess education levels and learning styles in order to design effective health education materials
Assisted Project Director in designing and creating TB and Reproductive Health curriculum for Roma Peer Health Mediators
Served as ambassador from Dartmouth Medical School to medical school in Transylvania for the establishment of professional exchange program between the two schools

10/2003 - 05/2005 **Average Hours/Week:** 5
Planned Parenthood of New England, NH, United States Of America
Volunteer
Conducted contraception and pregnancy counseling for new patients
Performed pregnancy and STI testing and pap smears
Spoke as student representative at regional board meetings

01/2003 - 08/2003 **Average Hours/Week:** 40
Harlem Lung Center, Columbia University, NY, United States Of America
Research Assistant, Emily DiMango, MD, Columbia Uni. Medical Center
Conducted clinical visits for NIH study on asthma treatment
Performed pulmonary function and other biomarker tests on asthmatics in and around the Harlem community
Processed and analyzed sputum samples for biomarker determinants
Recruited new study participants
Monitored ongoing participation and evaluation of participants within the clinical trial

09/2001 - 04/2002 **Average Hours/Week:** 10
Portland State University, OR, United States Of America
General Chemistry Workshop Leader
Led two weekly general chemistry workshops to classes of approximately ten students each

05/2000 - 08/2000 **Average Hours/Week:** 40
Project Renewal, NY, United States Of America
Paid Intern, Medical clinic/ Mobile Medical Van
Developed and administered program to enroll homeless in NY State Medicaid program
Performed office duties in the medical center of homeless shelter
Assisted primary care provider on mobile medical van

Volunteer Experience

07/2007 - **Average Hours/Week:** 1
Hosptial Ethics Committee, RI, United States Of America
Student Representative
Responsibilities include attending ethics committee meetings and discussing ongoing cases

08/2004 - 05/2005 **Average Hours/Week:** 6
Dartmouth International Health Group, NH, United States Of America
Student Coordinator
Responsibilities included speaker selection, procurement and distribution of medical supplies for members of Dartmouth¿s community traveling to developing
countries, and selection of scholarship recipients for summer research projects

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Volunteer Experience

09/2003 - 05/2005 **Average Hours/Week:** 6
Dartmouth Medical Students for Choice, NH, United States Of America
Student Coordinator
Responsibilities included recruitment, fund raising, speaker selection, and event planning for Dartmouth's MSFC chapter
Coordinated MSFC's regional conference at Dartmouth in 2004
Sent by Dartmouth to MSFC national conferences in 2004, 2005

09/2003 - 05/2005 **Average Hours/Week:** 8
Dartmouth Medical School Class of '07, NH, United States Of America
Student Needs Assistant Program Respresentative
Selected by medical school class to serve as student advocate and mediator between medical students and Dartmouth's administration.
Primary achievements included representing a number of minority student issues to the Dartmouth administration.

02/2001 - 11/2001 **Average Hours/Week:** 10
Outside - In, OR, United States Of America
Volunteer
Volunteered in homeless youth advocacy center
Developed Outside In's Youth Involvement Program, YIP.
Prepared and served meals to Portland's homeless youth

05/2000 - 08/2000 **Average Hours/Week:** 6
Mount Sinai Adolescent Health Center, NY, United States Of America
Research Assistant
Gathered and entered data for studies on urban adolescents
Administered surveys to study participants

09/1999 - 08/2000 **Average Hours/Week:** 12
Project Health, NY, United States Of America
Fitness and Nutrition Program Coordinator
Developed and coordinated education program for female youth at risk for obesity
Worked with medical professionals to create a nutrition program compliant with federal guidelines for nutritional standards
Recruited medical professionals from Harlem community to act as mentors to program volunteers and participants

11/1998 - 05/1999 **Average Hours/Week:** 8
Tostan, Senegal
Intern, Female Circumcision Project
Worked with international NGO
Participated in field visits to rural communities to record stories of female circumcision to be used in organization¿s publication

Research Experience

09/2006 - 06/2007 **Average Hours/Week:** 40
Biomedical Center, Russia
NIH/Fogarty Ellison Clinical Research Fellow, Andrei Kozlov, PhD, Robert Heimer, PhD
Completed two research projects
Investigated STI and blood-born virus rates among 387 Russian IDUs
Developed, administered and analyzed surveys evaluating HIV serostatus partner notification among 203 HIV-infected patients presenting to the City AIDS Center in St. Petersburg

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Research Experience

03/2006 - 04/2006 **Average Hours/Week:** 40
Sihanouk Hosptial Center Of Hope, Brown University, Cambodia
Researcher, Susan Cu-Uvin, Brown University
Conducted retrospective Chart analysis of 304 HIV-infected women
Compared the efficacy and feasibility of two cervical cancer screening methods in HIV-infected women in low-resource areas
Assisted MD with colposcopy and pap smears in HIV clinic

10/1998 - 05/1999 **Average Hours/Week:** 10
Association Senegalaise Pour le Bien-Etre, Senegal
Intern, Ibraham Camera, MD
Worked at the first reproductive health center in Dakar
Wrote and conducted study designed to test knowledge of sexual education among female, urban, Muslim, Senegalese adolescents
Identified health education needs and conducted neighborhood sexual education forums for local families

Publications/Presentations/Poster Sessions

Presentation Poster

Aboshady, H., Guico, M., Yoburn, D., Lockridge, L., MD, Davidson, A.. (2006, May). *NSAID Induced Minimal Change Disease and Acute Tubular Necrosis in a Patient with Thin Glomerular Basement Membrane Disease.* Poster presented at Brown University, Providence, RI.

Davidson A, Toussova O., Verevochkin S., Heimer R., and Kozlov A. (2007, June). *Socio-demographic Characteristics, Sexual Risk Behavior and Prevalence of STIs among Female and Male Injecting Drug Users.* Poster presented at Biomedical Center, St. Petersburg, .

Kruy, L., Davidson, A., Harwell, J., De Munter, P., Sovannara, T., Pichsovannary, S., Haverkamp, M., Tharpe, L., Boardman, Lynen, L., Cu-Uvin, S.. (2006, August). *Comparison of visual inspection of the cervix with acetic acid (VIA) and Pap smear among HIV-infected women in Phnom Penh, Cambodia.* Poster presented at XVI International AIDS Conference, Toronto, ON.

Other Articles

Davidson A, Toussova O., Verevochkin S., Heimer R., and Kozlov A. (2007, May 1). *Socio-demographic Characteristics, Sexual Risk Behavior and Prevalence of STIs among Female and Male Injecting Drug Users Recruited by Respondent-Driven Sampling in Saint-Petersburg, Russia.* Russian Journal of AIDS, Cancer and Public Health, 11, 56. Pub Status: Published.

Hobbies & Interests

[redacted]

Language Fluency (Other than English)

Conversationally fluent in French
Familiarity with Russian

COMMONWEALTH OF MASSACHUSETTS, BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 – (617) 654-9810 www.massmedboard.org

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 you[redacted]

Applicant's Signature: Autumn Davidson Date of Birt[redacted]

Print or Type Name: Davidson (Last name) Autumn (First Name) S. (Middle Initial) Social Security No[redacted]

Other Name(s) _____ (Please type or print name(s))

Name of Medical School: Dartmouth Medical School

Address: Rope Ferry Rd City: Hanover State or Province: NH

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: Columbia University

Undergraduate School Address: 2970 Broadway, New York, NY 10027

Continued on page 2

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Enrollment and Participation: Our records indicate that

Davidson (Last name) Au Tumr (First name) S. (Middle initial)

(type or print the applicant's name):

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/13/03	6/18/04	/ /	/ /
	8/24/04	5/28/05	/ /	/ /
	/ /	/ /	/ /	/ /

The applicant attended 76 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one ☑ was NOT awarded a degree in Transferred to Brown medical 6/05 on (month/day/year) / /

☐ will be awarded on / / **(Form B must also be completed and returned with this Form A)**

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. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)		[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?		

[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: Joan M. Monahan

Print Name: Joan M Monahan

Title: Registrar

Date: APR 28 2008 Telephone: (603 650-2248

This form will not be accepted unless it is stamped with the institutional seal or notarized.

04/11/2008 16:14 9563658821 ENRIQUE ESCOBEDO MD PAGE 02

COMMONWEALTH OF MASSACHUSETTS, BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 – (617) 654-9810 www.massmedboard.org

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

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

Print or Type Name: Davidson (Last name) Autumn (First Name) S (Middle Initial) Social Security N[redacted]

Other Name(s) _____ (Please type or print name(s))

Name of Medical School: Warren Alpert Medical School of Brown University

Address: 97 Waterman St. Box G-A213 City: Providence State or Province: RI

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:

Brown University

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: Columbia University | Portland State University

Undergraduate School Address: New York City (undergraduate) | Portland OR (premedical)

Continued on page 2

Enrollment and Participation: Our records indicate that

(type or print the applicant's name): Davidson (Last name) Autumn (First name) S. (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	7/5/05	6/23/06	/ /	/ /
	7/3/06	6/22/07	/ /	/ /
	7/2/07	5/25/08 *	/ /	/ /

The applicant attended 80 total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year

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

MD ☒ will be awarded on 5/25/08 **(Form B must also be completed and returned directly to the Board)**

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

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)		[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?		

COMMENTS: * Please see attached letter.

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: [signature]

Print Name: Alexandra Morang

Title: Dir. of Medical Student Affairs & Registrar

Date: 4/14/08 Telephone: (401) 863-1641

This form will not be accepted unless it is stamped with the institutional seal or notarized.

08/19/08 SI 08/19/08

BROWN
Alpert Medical School

OFFICE OF MEDICAL STUDENT AFFAIRS

08/13/08 91 19

April 11, 2008

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4
Boston, Massachusetts 02118

To Whom It May Concern:

Subject: Autumn Davidson, MD 2008

This letter is to certify that Autumn Davidson enrolled at The Warren Alpert Medical School of Brown University on July 5, 2005 and is expected to receive her MD degree on May 25, 2008.

Autumn was admitted as a third-year advanced transfer student from Dartmouth Medical School.

After completing her third year of medical education, Autumn went on approved fellow status to do research from October 2, 2006 to June 22, 2007. She then returned to complete her academic requirements, and is expected to receive her MD degree on May 25, 2008.

If you require any additional information, you can contact me at 401-863-1641.

Sincerely,

Alexandra Morang
Director of Medical Student Affairs

06/13/08 21 24

DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physician's Name: Autumn (First Name) S (Middle Initial) Davidson (Last Name)

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

- ☑ Medical school verification form
- ☑ Medical school transcripts
- ☐ Letter from program director
- ☐ Evaluations
- ☐ Leave of absence
- ☐ Other documents (describe): _____

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

Designated Official: Dawn Hemp Date: 4/18/08

Title: Administrator Grad Med Ed

Name of Institution: UMass Medical School

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

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

Zip/Limitedrelease/2

KY
2-18-09

Check #: 250422731

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

RENEWAL APPLICATION - LIMITED LICENSE

RECEIVED
FEB 13 2009
Board of Registration in Medicine
03/03/09 81

IMPORTANT: Renewal fee is $100.00. Please read the attached instructions before completing application.

SECTIONS "A"AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

1. Name: (Last) Davidson (First) AuTumn (MI) A
2. Mailing Address [redacted] Telephone #: [redacted]
   City: [redacted] State: [redacted] Zip: [redacted]
3. Name of Training Hospital: UMass Memorial Hospital
4. Current Limited License Number: 237548
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license or training license (limited).
   ___ ☐ Full ___ ☐ Full ___ ☒ Limited (emer) ___ ☐ Limited

SECTION B: To be completed by the program director. [redacted]

Is the above named physician in good standing in the training program?
Has the physician been subject to past or pending disciplinary action in this program?
Print Name: Robert E. Berry Jr MD Date: 1/26/09
Signature of Program Director: Robert E Berry Jr MD Telephone 508-334-8459

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

This certifies that AuTumn Davidson (Name of Applicant) has been appointed as an ☐ Intern ☑ Resident ☐ Fellow

Department of OB/GYN Subspecialty ——

and as a PGY 2 or Fellowship year: _____ Academic Year: From: 07/01/09 To: 07/01/2010

Is the program accredited by the ACGME: ☑ Yes ☐ No
If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Marilyn Reeds MPH (Print Name) Date: 2/9/09
Designated Official's Signature: M P Leeds Telephone #: 5085562903
Designated Official's Title: Admin. Director

NAME: AuTumn Davidson

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A.
If you answer YES to any of these questions, you must provide details on Limited Supplement attached

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

		YES	NO
16-A.	Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?		[redacted]
16-B.	Have you, for any reason, been placed on probation in any postgraduate training program?		
17.	Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18.	Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19.	Have you voluntarily surrendered a license to practice medicine or any healing art?		
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21.	Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).		
22.	Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you voluntarily relinquished medical staff membership?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26.	Have you been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

(Continued on page 3)

NAME: AuTumn Davidson

CONFIDENTIAL MEDICAL INFORMATION

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

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEW

		YES	NO
30.	Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		[redacted]
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 16-35 change while your application is pending, you must notify the Board of the new information immediately.

(Continued on page 4)

03/03/09 S1 4

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 1/22/09

Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

Revised: 8.12.08

Print Form

03/03/09 S1

Limited License

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Autumn Davidson
(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 Telephone: (781) 876-8210 Fax: (781) 876-8383
www.massmedboard.org 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.

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

2/4/09
Date of Signature

Davidson, AuTumn S.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

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

Physician Name: Autumn S Davidson, M.D. **License No.:** 237548

1. **Training Program**

   Current Training Program

   Facility: UMass Memorial Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Umass Memorial Health Care
   55 Lake Avenue North
   Worcester
   Massachusetts - 01655
   United States of America

   Home Address: [redacted]

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 237548

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

SECTION B: To be completed by the Program Director.

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

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

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

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

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

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

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

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

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

[redacted]

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

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

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? [redacted]

Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

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

☒ **I have reviewed the 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 Limited Renewal Application

Physician Name: Autumn S Davidson, M.D. **License No.:** 237548

1. **Training Program**

   Current Training Program

   Facility: UMass Memorial Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Umass Memorial Health Care
   55 Lake Avenue North
   Worcester
   Massachusetts - 01655
   United States of America

   Home Address: [redacted]

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 237548

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

SECTION B: To be completed by the Program Director.

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

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

Name: Petra Belady MD **Date:** 3/12/2010
Designation: Program Director - Ob Gyn **Telephone:** (508) 334-8459

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

This certifies that **Autumn S Davidson** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Marilyn P. Leeds **Date:** 3/15/2010
Designated Official's Title: Administrative Director Graduate **Telephone:** (508) 856-3250

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

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

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

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

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

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

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

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

14. Have you voluntarily relinquished medical staff membership?

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

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

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

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

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

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

Physician Name: Autumn S Davidson, M.D. **License No.:** 237548

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? No

Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

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

☒ **I have reviewed the 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 Limited Renewal Application

Physician Name: Autumn S Davidson, M.D. **License No.:** 237548

1. **Training Program**

   Current Training Program

   Facility: UMass Memorial Medical Center
   Program: Obstetrics and Gynecology

2. **Address & Contact Information**

   Mailing Address:
   Umass Memorial Health Care
   55 Lake Avenue North
   Worcester
   Massachusetts - 01655
   United States of America

   Home Address: [redacted]

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

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 237548

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

SECTION B: To be completed by the Program Director.

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

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

Name: Petra Belady MD **Date:** 3/21/2011
Designation: Program Director - Ob Gyn **Telephone:** (508) 334-8459

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

This certifies that **Autumn S Davidson** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

Designated Official's Name: Marilyn P. Leeds **Date:** 3/21/2011
Designated Official's Title: Administrative Director Graduate **Telephone:** (508) 856-3250

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

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

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

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

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

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

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

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

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

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

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

Physician Name: Autumn S Davidson, M.D. **License No.:** 237548

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? No

Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

☒ **I have reviewed the 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.**

LHD

RECEIVED
MAY - 7 2014
Board of Registration in Medicine

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230

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:"**

(type or print clearly)

SEND LICENSE VERIFICATION TO: Michigan Dept. of Licensing, Board of Medicine

ADDRESS: P.O. Box 30192

CITY: Lansing, MI STATE: MI ZIP: 48909

(TYPE OR PRINT)
PHYSICIAN'S NAME: Autumn Davidson

BUSINESS ADDRESS: 5841 S. Maryland Ave

CITY: Chicago STATE: IL ZIP: 60637

MASSACHUSETTS LICENSE NUMBER: 237548

SIGNATURE OF PHYSICIAN: _____

Signed under the penalties of perjury

DATE: 5.2.14

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

Date Received: 5/7/14

Check #: 6402

Check Amount: $ 10.00

Initials: CN

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

RECEIVED
JAN 30 2017
Board of Registration in Medicine

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(Please type or print clearly.)

SEND LICENSE VERIFICATION TO: Washington State Medical Quality Assurance Commission

ADDRESS: PO Box 47866

CITY: Olympia STATE: WA ZIP: 98504 - 7866

PHYSICIAN'S NAME: Autumn Davidson

BUSINESS ADDRESS: 820 S. Wood St.

CITY: Chicago STATE: IL ZIP: 60640

MASSACHUSETTS LICENSE NUMBER: 237548

SIGNATURE OF PHYSICIAN: _____

Signed under the penalties of perjury

DATE: 1/25/17

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

Date Received: 1/30/17
Check #: 163
Check Amount: $ 10.00
Initials: LS