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/medboard

FULL LICENSE APPLICATION

263885

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

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

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

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

Brown | Cari | Ellen | |
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

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

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

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

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

NPI (National Provider Identifier) Number: 1699061580

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

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

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

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

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

Business Address: 1200 Old York Rd Telephone: 215-481-7829
Number and Street

Abington | PA | 19001
City | State/Province/Territory | Zip (or postal) Code

E-mail Address: [redacted] Fax number: 215-481-2048

Are you applying for licensure through FCVS? ☐ **Yes** ☑ **No**

*** The Board will use your Mailing Address for all correspondence**

Date Received: 5 / 11 / 15

Check #: 474

Check Amount: $ 600.00

Initials: LS

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

Name: Brandeis University Degree: B.S. Year: 2001 Year: 2005
Street: 415 South St City: Waltham State: MA

Name: Degree: Year: Year:
Street: City: State:

Medical School

Name: Temple University School of Medicine Degree: M.D.
Street: 3500 N. Broad St City: Philadelphia State: PA

Name: Degree:
Street: City: State:

Medical School Graduation Date: 5 / 2011
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

		From	To
Facility: Abington Memorial Hospital	PGY Year: 1	6 / 2011	6 / 2012
Specialty: OB/Gyn	City: Abington	State: PA	
Facility: Abington Memorial Hospital	PGY Year: 2	6 / 2012	6 / 2013
Specialty: OB/Gyn	City: Abington	State: PA	
Facility: Abington Memorial Hospital	PGY Year: 3	6 / 2013	6 / 2014
Specialty: OB/Gyn	City: Abington	State: PA	
Facility: Abington Memorial Hospital	PGY Year: 4	6 / 2014	/
Specialty: OB/Gyn	City: Abington	State: PA	
Facility:	PGY Year:	/	/
Specialty:	City:	State:	

Examination History

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

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

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

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Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

	From	To
Facility:___Abington Memorial Hospital _____ Position:OB/GYN Resident	_6_/_2011_	_6_/2015

Street:____1200 Old York Rd_____ City:_____Abington_____ State: PA

6/2015-Present- Unemployed due to completion of residency and period of maternity leave.

1. List other states (abbreviations) where you are currently or have ever had a full license: _PA_

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): ~~Board Eligible in OB/GYN, certification pending.~~ _____

error CB 12/15

4. List your practice specialt(ies):__OB/GYN_____

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? ☒ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)

7. Reason for requesting a Massachusetts medical license: Plan to start employment with Harvard Vanguard Medical Associates in October of 2015. _____

8. Name of Facility: Harvard Vanguard Medical Associates_____
   Address:____40 Holland St_____ City: Somerville_____

9. Anticipated starting date in Massachusetts: __10___/__1___/___15__

10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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

_____Cari Brown_____ _____7___/__17____/__2015_____
Signature of Applicant Month Day Year

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Cari Brown
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

Applicant's Signature — Date of Signature: 3/13/15

Brown, Cari E.
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
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, Cari Brown,
(type or print name)

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

SIGNED: _____ DATE: 3/13/15

Social Security Number: [redacted]

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

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

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: 3/13/15

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

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

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

SECTION 1. DEMONSTRATING PROFICIENCY

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

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

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

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

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

SECTION 3. SIGNATURE

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

NAME:___Cari Brown_____DATE: __7/17/15_____

Cari Brown, M.D.

Personal Information

Date of Birth: [redacted]

Place of Birth: [redacted]

Address: [redacted]

Phone: [redacted]

Email: [redacted]

Education

Medical School: M.D. - Temple University School of Medicine, August 2007-May 2011

Undergraduate: B.S. - Anthropology and Biology, Brandeis University, August 2001-May 2005

Medical Licensure

Pennsylvania License Number - MD453255

Honors and Awards

Dean's Award Scholarship
Temple University School of Medicine, 2007. Merit scholarship awarded to incoming medical students.

Resident Research Award
Abington Memorial Hospital, Department of Obstetrics and Gynecology, 2014. Annual award for a third year resident, based on presentation of original research.

Society for Maternal Fetal Medicine Award for Excellence in Obstetrics
Abington Memorial Hospital, 2014. Annual award to a resident displaying distinction in provision of obstetric care.

Previous Employment

Resident in Obstetrics and Gynecology
Abington Memorial Hospital, Abington, PA
June 2011-June 2015

Technical Research Assistant and Laboratory Radiation Safety Officer, September 2005- July 2007
Lipid Metabolism Unit, Massachusetts General Hospital, Boston, MA

Present Position

Maternity Leave, June 2015-Present

Bibliography

Journals

Fitzgerald ML, Xavier R, Haley KJ, Welti R, Goss JL, Brown CE, Zhuang DZ, Bell SA, Lu N, McKee M, Seed B, Freeman MW. *ABCA 3 inactivation in mice causes respiratory failure, loss of pulmonary surfactant, and depletion of lung phosphatidyl glycerol.* J Lipid Res 48: 621-632, 2007.

Tamehiro N, Zhou S, Okuhira K, Benita Y, Brown CE, Zhuang DZ, Latz E, Xavier RJ, Freeman MW, Fitzgeral ML. *SPTLC1 Binds ABCA1 to negatively regulate trafficking and cholesterol efflux activity of the transporter.* Biochemistry 47 (23): 6138-47, 2008.

Poster Presentation

Maher Z, Brown C, Schuerch L, Trydestam C, Wong L, Hurley B, Matthews G, Burlingame E, Butera D, Lyons P, Barry T, Reeves K. *Temple University Emergency Action Corps: Service Learning and the Makings of a Successful Student Run International Disaster Response Trip.* Poster Presented at the American Association of Medical Colleges Annual Meeting, 2008.

Book Chapters

Primary and Preventative Care
The Puerperium
Cari Brown, Edited by Stephen G. Somkuti. Pearls of Wisdom, Obstetrics and Gynecology Board Review, Fourth Edition. McGraw-Hill, 2014.

In Preparation

Auscultation Alone as a Method of Identifying Fetal versus Maternal Heart Sounds. Brown C, Mackey A. An evaluation of 98 labor and delivery providers and their ability to determine the source of fetal heart sounds without additional clinical information.

Is Hypothyroidism a Risk Factor for Types of Uterine Cancer? Ward C, Brown C, Shahin M, Edelson M. Retrospective cohort study of 600 patients with uterine cancer evaluated for type of cancer and concomitant thyroid disease.
-Selected for oral presentation, Mid –Atlantic Gynecologic Oncologic Society, October, 2014.
-Selected for poster presentation Society of Gynecologic Oncologists Annual Meeting, 2015.

Committees

Obstetric Triage Work Group

Obstetric Multidisciplinary Work Group

Obstetrics and Gynecology Resident Education Committee

Admissions Committee, Temple University School of Medicine at St. Luke's University Health Network (member 2010-2011)

International Experience

Child Family Health International, Puerto Escondido, Mexico - engaged in medical Spanish lessons, assisted in the regional public hospital and a rural clinic, and assisted with training activities for traditional birth attendants. Oct, 2013.

Amerispan Study Abroad, Heredia, Costa Rica - participated in Spanish immersion program, assisted with clinical care in a private general medical clinic. Feb, 2011.

Temple University Emergency Action Corps - participated in planning, executing and documenting weeklong service trips to Bolivia and El Salvador to assist in disaster relief efforts. Mar, 2008; Mar, 2010.

Volunteer and Extracurricular Activities

Co-president, Medical Students for Choice, Temple University Chapter, 2008-2009.

Vice President, American Medical Student Association, Temple University Chapter, 2008-2009.

Patient Escort, Planned Parenthood, Philadelphia, PA, 2008-2009.

Languages

Working knowledge of medical Spanish

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MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of your current and all past liability carrier(s). You must provide your malpractice history reports if you ever had a full license in any state. You do not need to supply your malpractice history reports while participating in an ACGME postgraduate training program unless you had a full license or you were named in a malpractice case. This form must be returned to the Board with your license application.

Please provide the following information on the malpractice history report:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: Please report any open or closed cases that have gone to trial, whether or not monies were paid, and provide a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant. If the applicant does not have any claims history, please indicate that on your letterhead. If your company's name has changed, please provide any former company names. The information should be sent to the applicant.

Liability Carrier: Cossett Risk Retention Group From: 6 / 2013 To: 6 / 2015
City: Burlington State: VT Policy #: RRG-14-600

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy #: _____

Applicant's signature: _____ 4 / 3 / 15
Date

Print Name: Cori Brown

Address: [redacted]

City: [redacted] State: [redacted] Zip code: [redacted]

Additional forms available at the Board's website at www.mass.gov/massmedboard.

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

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

Waiver for Release of Information

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

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

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

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

Name of Medical School: Temple University School of Medicine

Address: 3500 N Broad St City: Philadelphia State or Province: PA

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: Brandeis University

Undergraduate School Address: 415 South St, Waltham MA 02453

Enrollment and Participation: Our records indicate that (print the applicant's name): Brown (Last Name) Cari (First Name) E. (Middle Initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/13/07	6/4/08	5/17/10	5/6/11
	8/11/08	4/10/09	/ /	/ /
	5/18/09	5/7/10	/ /	/ /

Graduation Date (month/year): 5/11

The applicant attended 163 **total weeks *or*** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

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

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

Seal Verified
DATE: 5/12
INITIALS: NG

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

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Jane E. Stringer

Print Name: Jane E. Stringer

Title: DIRECTOR OFFICE OF STUDENT RECORDS

Date: 4/10/15 Telephone: (215) 707-2079

E-mail address: dmge temple.edu

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

TEMPLE UNIVERSITY

OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION

BY AUTHORITY OF THE BOARD OF TRUSTEES AND UPON RECOMMENDATION
OF THE FACULTY HEREBY CONFERS UPON

Cari Ellen Brown

THE DEGREE OF

Doctor of Medicine

PROVIDED BY APPLICANT

TOGETHER WITH ALL THE RIGHTS PRIVILEGES AND HONORS APPERTAINING
THERETO IN RECOGNITION OF THE SATISFACTORY COMPLETION
OF THE COURSE PRESCRIBED BY THE FACULTY OF THE UNIVERSITY

IN TESTIMONY WHEREOF THE UNDERSIGNED HAVE SUBSCRIBED
THEIR NAMES AND AFFIXED THE SEAL OF THE UNIVERSITY

GIVEN AT PHILADELPHIA PENNSYLVANIA ON THIS SIXTEENTH DAY OF
MAY TWO THOUSAND AND ELEVEN

I certify this is a true and actual copy of the original with no alterations or corrections.

Sharon A. Kels

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Sharon A. Kels, Notary Public
Palmer Twp, Northampton County
My commission expires April 11, 2017

Patrick J. O'Connor
CHAIR OF THE BOARD OF TRUSTEES

Gregg E. Moore
SECRETARY

TEMPLE UNIVERSITY
INCORPORATED MAY 19, 1888
PERSEVERANTIA VINCIT
Of The Commonwealth System Of Higher Education

PRESIDENT

DEAN

Seal Verified
DATE: 5/6
INITIALS: MG

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

Sealed Envelope
Initials: KG

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

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

PHOTOGRAPH

A
pl
pl d.

Y
pr ic.

Signature of applicant

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

Jennifer B Meissner
Signature of Notary

7/26/2016
My commission expires

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
JENNIFER B. MEISSNER, Notary Public
Abington Twp., Montgomery County
My Commission Expires July 26, 2016

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

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

Cor. Brown
(name of applicant)

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

Signature of Certifying Physician

MD071182 PA
License Number State

Bethany Perry
Type or print name clearly

Address: [redacted]

City [redacted] State: [redacted] Zip: [redacted]

Telephone: [redacted]

Date: 4/3/15

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

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POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/13/15

Print or Type Name: Cari Brown

Name of Institution: Abington Memorial Hospital

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: ABINGTON MEMORIAL HOSPITAL

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that CARI BROWN M.D participated in the following program:
(Print applicant's name)

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
RESIDENCY	1	OB/GYN	06/24/11	06/23/12	YES	ACGME
RESIDENCY	2	OB/GYN	06/24/12	06/23/13	YES	ACGME
RESIDENCY	3	OB/GYN	06/24/13	06/23/14	YES	ACGME
RESIDENCY	4	OB/GYN	06/24/14	06/23/15	~~(illegible) NO~~ YES (AW)	ACGME

(Continued on page 2)

APPLICANT'S NAME: CARI BROWN M.D.

POSTGRADUATE VERIFICATION FORM PAGE - 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

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

Seal Verified 5/6

DATE:

INITIALS: MO

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other:

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

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

Certification: I hereby certify that the above information is correct to the best of my knowledge.

Program Director's Signature: A Mackey

Print Name: Amy Mackey

Academic Title: Program Director

Telephone: (215) 481-4211 Today's Date: ~~8/6/15~~ 7/31/15

E-mail address: samackey@abingtonhealth.org

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
www.dos.pa.gov

04/01/2015

VERIFICATION/CERTIFICATION OF LICENSE

This is to certify that the individual named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	Brown, Cari
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD453255
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	09/18/2014
LICENSE EXPIRATION DATE:	12/31/2016
DISCIPLINARY HISTORY:	[redacted]

Ian J. Harlow, Acting Commissioner
Bureau of Professional and Occupational Affairs

From: st-medicine@pa.gov
To: BORIM License Verification (MED)
Subject: PENNSYLVANIA VERIFICATION/CERTIFICATION OF LICENSE - MD453255
Date: Wednesday, April 01, 2015 9:05:52 PM
Attachments: 3269825_LIC_12_MA - Massachusetts Board of Registration in MedicineApr_1_2015_7_22_09_483PM.PDF

Attached is a VERIFICATION/CERTIFICATION OF LICENSE for:

Licensee Information	
Licensee #	MD453255
Licensee Type	Medical Physician and Surgeon
Last Name	Brown
First Name	Cari

Open the attachment to view and print the document. To verify the authenticity of the letter and/or to download any disciplinary action documents if exist for the requested licensee, please click this link https://www.mylicense.state.pa.us/L2KSupportSite/ReceiverVerification.

Verification Code:98AB2DCA-4797-43A4-9BAF-621485DA0103.
Please note that this link cannot be forwarded and will only be available for 30 days from the date of this email.

Please contact the Pennsylvania board/commission at 7177831400 or email st-medicine@pa.gov for any questions.

Thanks,
BPOA

PRINT NAME: Cori Brown DATE: 3 / 13 / 15

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

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

PRINT NAME: Cori Brown DATE: 3/13/15

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

PRINT NAME: Cari Brown DATE: 3 / 13 / 2015

CONFIDENTIAL INFORMATION

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

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

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

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

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

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

PRINT NAME: Ceri Brown DATE: 3 / 13 / 15

CERTIFICATIONS

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

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

Applicant's Signature: Date: 3 / 13 / 15

FEB 14 2017

4 February 2017

Massachusetts Board of Registration in Medicine
Patient Care Assessment Unit 200
Harvard Mill Square, Suite 330
Wakefield, MA 01880
800.377.0550

Re: Written grievance for Dr. Cari Brown, MD (Mount Auburn Hospital and Harvard Vanguard Medical Associates)

Date of violation: [redacted] **2016**
Provider Name: **Sharon Mullen, Mount Auburn Hospital**
Provider ID Number: **1407865439**
Name of Staff**: Cari Brown, MD**:
www.mountauburnhospital.org/find-a-provider/profile/cari-brown/

Description:

Cari Brown improperly preformed a [redacted] on our newborn baby at Mount Auburn Hospital on 6 May 2016. He was rushed by ambulance to Boston Children's Hospital for reconstructive surgery. The urological surgeon stated that standard procedures were not followed during the [redacted]. Brown is on record stating that there was no malfunction of tools, but that she did not follow procedure, which resulted in the emergency surgery.

Brown treated our family terribly before and after her treacherous actions on our newborn. We are haunted every day by her irresponsible actions. We are filing a lawsuit that may help alleviate the future pain and suffering our family will have to endure.

Please share this information widely so that other families can be protected. I was very alarmed to learn that two of my coworkers at Tufts University were seeking prenatal care at Mount Auburn and were seen by Brown on more than one occasion. Obviously, Mount Auburn has done nothing to discipline or stop Brown from practicing on other patients.

Please see attached narrative, which was documented for the lawsuit.

Sincerely,

[redacted]

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
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GEORGE ABRAHAM, MD
Physician Member
GEORGE ZACHOS, ESQ
Executive Director

April 4, 2017

[redacted]

RE: Cari E. Brown, M.D.
Docket Number: 17-106

Dear Ms. Rowe:

The Board of Registration in Medicine has received your complaint regarding the above named physician. The physician has been asked to respond in writing to your complaint.

If you wish to bring additional information about your complaint to the attention of the Board, please provide it to me in writing at the address above. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

Once our review of your complaint has been completed, you will receive a letter informing you of the outcome.

Thank you for bringing this matter to the attention of the Board.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/df

Board of Registration in Medicine

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Wakefield, Massachusetts 01880
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Physician Member

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Physician Member

GEORGE ZACHOS, ESQ
Executive Director

October 5, 2017

[redacted]

RE: Cari E. Brown, M.D.
Docket Number: 17-106

Dear Ms. [redacted]

Thank you for the information that you provided to the Board of Registration in Medicine. A copy of your complaint, referenced above, was sent to the physician, who was required to respond in writing. Enclosed please find a copy of the physician's response.

After considering this matter on September 28, 2017, the Board's Complaint Committee did not recommend disciplinary action and closed the complaint. However, your complaint and the physician's response will be placed in the physician's file at the Board.

Thank you again for bringing this matter to the Board's attention.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/df

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Physician Member
GEORGE ZACHOS, ESQ
Executive Director

April 4, 2017

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Cari E. Brown, M.D.
[redacted]

[redacted]

Re: Docket Number: 17-106

Dear Dr. Brown:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. Please provide a written response to the issues raised in the enclosed material. As part of your response, you may include any materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response and any attachments.

The Health Insurance Portability and Accountability Act (HIPAA) provides that otherwise protected health information may be disclosed to a health oversight agency for activities that include disciplinary actions. *See* 45 CFR section 164.512 (d). The Board clearly meets the definition of a health oversight agency. *See* 45 CFR section 164.501.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee. Your response must be sent to me within thirty days of this letter.

Upon receipt, your response will be reviewed to determine the course of action. You will be notified of this decision. Thank you for your attention to this request.

Very truly yours,

Paula Hannon
Consumer Protection Coordinator

PH/df
Enclosure

CAPPLIS, CONNORS & CARROLL, PC

ATTORNEYS AT LAW

www.ccclaw.org

Sean E. Capplis • ^
Matthew R. Connors • *
Judith A. Carroll ››
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Sandra P. Wysocki Capplis
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□ Admitted in California
* Admitted in Connecticut
• Admitted in New Hampshire
›› Admitted in New York
^ Admitted Rhode Island

Of Counsel
Hon. Frances A. McIntyre (Ret.)

mconnors@ccclaw.org

May 2, 2017

Paula Hannon, Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Dear Ms. Hannon:

RE: [redacted] and [redacted]
VS: Carri Brown, M.D.
Docket # 17-106
Our File: CRICO1150

Kindly allow this letter to serve as my notice of appearance on behalf of Carri Brown M.D. A copy of Dr. Brown's response to the complaint is enclosed.

If you need any additional information from Dr. Brown, please let me know.

Very truly yours,

MATTHEW R. CONNORS

MRC/
Enclosure

Harvard Vanguard
Medical Associates
Atrius Health

Somerville
40 Holland Street
Somerville, MA 02144
617-629-6000 tel

www.harvardvanguard.org

May 2, 2017

Paula Hannon
Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mills Square, Suite 330
Wakefield, MA 01880

RE: Docket Number: 17-106

Dear Ms. Hannon:

Thank you for providing me with a copy of the complaint that has been filed by [redacted] A copy of my note from the procedure is attached. My response follows.

[redacted] an [redacted] are understandably upset by the unfortunate complication that occurred during [redacted] This complaint is the latest in a series of complaints that they have filed against me and they have indicated that they are also planning to file a lawsuit against me. It appears that their anger and planned lawsuit has caused them to include in their complaint very odd and inflammatory allegations suggesting that I am depressed or have some psychological problem. I would invite the Board to address these allegations, if it feels the need to do so, with any physician who has practiced with me or with the other physicians that are identified in the complaint.

With respect to the treatment at issue, I was in the nurses' station on the Stanton postpartum floor and was asked by the patient's nurse to perform the [redacted] on [redacted] 2016. The obstetrician, Dr. [redacted] was not available at that time to perform the circumcision. I entered the room and Ms. [redacted] was on the phone. I waited until Ms [redacted] could talk and I introduced myself. I explained that I was an obstetrician for another group but was available to perform their baby's [redacted] if they wanted me to. I then verbally reviewed the

preprinted informed consent form with the parents and offered them the opportunity to ask me any questions. The parents asked if they could watch the [redacted] and I advised that my practice was not to allow parents to observe [redacted]. They then discussed this and decided that they wanted to go forward with the [redacted] and Ms. [redacted] signed the consent form. I did explain the risks and potential complications.

At the time, I believed that I exercised my judgment appropriately and used the surgical devices, including the [redacted] appropriately. I did not ask for guidance in the use of the [redacted] prior to starting the procedure. I was trained using the [redacted], and I use it for all [redacted] I perform. I would estimate I have performed approximately 80 to 100 [redacted] in my career.

In retrospect, only with knowledge of the outcome, it appears that a larger [redacted] and/or less [redacted] During the procedure, I did adjust the [redacted] to achieve what I believed at the time to be the proper position for the [redacted] the [redacted] may have resulted in an improved outcome. Unfortunately, in an effort to [redacted] for the proper cosmetic effect, too much [redacted] removed from [redacted] even though it appeared to be appropriate during the procedure.

I explained the complication that occurred to the parents and explained that we were recommending transfer of the baby to Children's Hospital. The parents initially wanted a pediatric urologist to come to Mount Auburn Hospital to care for the baby but I explained to them that this was not possible. Dr. [redacted] a pediatrician who had been caring for the infant, as well as Dr. [redacted] the chair of the department of OB/GYN, and Dr. [redacted] the chair of pediatrics, both of whom I had asked for input as to management after recognition of this complication, were part of this conversation and participated in the discussion regarding our recommendation that the baby be transferred.

Unfortunately, there is no way to ensure that complications will not occur in surgical procedures. [redacted] have known complications. [redacted] Documented early complications such as [redacted] Late complications include [redacted] These complications can unfortunately occur irrespective of the type of [redacted] technique that is utilized.

I am very sorry that this complication occurred and I did my best to reach out to the parents to answer their questions and address their complaints and concerns. Prior to her leaving Mount Auburn Hospital and traveling to Children's Hospital, I provided Ms. [redacted] with my

personal cell phone number, and advised her that she could call with any questions, or that she could call simply to discuss these events if she would like. In the week after the procedure I called Ms. [redacted] and left a message. I told Ms. [redacted] that I wanted to know how she and the baby were doing and told her that I would be happy to talk with them if they desired. I did not receive a call back.

If you have any further questions, or need any additional information from me, please let me know.

Sincerely,

Cari Brown, M.D.

Board of Registration in Medicine

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Executive Director

October 5, 2017

Cari E. Brown, M.D.
C/o Matthew R. Connors, Esquire
Capplis, Connors and Carroll PC
18 Tremont Street- Suite 330
Boston, MA 02118

RE: Docket Number: 17-106

Dear Dr. Brown:

The Complaint Committee of the Board of Registration in Medicine met on September 28, 2017, and considered the above-referenced matter. We have decided not to recommend disciplinary action and closed the complaint.

However, information concerning this matter will be kept on file at the Board. We reserve the right to reopen the complaint should you commit any violation of Board statutes or regulations in the future.

Sincerely,

George M. Abraham, M.D.
Complaint Committee Chair

GMA/df

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cari E Brown, M.D. **License No.:** 263885

Current Status: Active **License Expiration Date:** 9/1/2020

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
Harvard Vanguard Medical Associates
40 Holland Street
Somerville
Massachusetts - 02144
United States of America
(215) 481-7824

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

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

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

9) **States where you were previously licensed**
Pennsylvania

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
Harvard Vanguard- Somerville	
Mount Auburn Hospital	

Winchester Hospital

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 36 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2020	12/31/2020	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

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

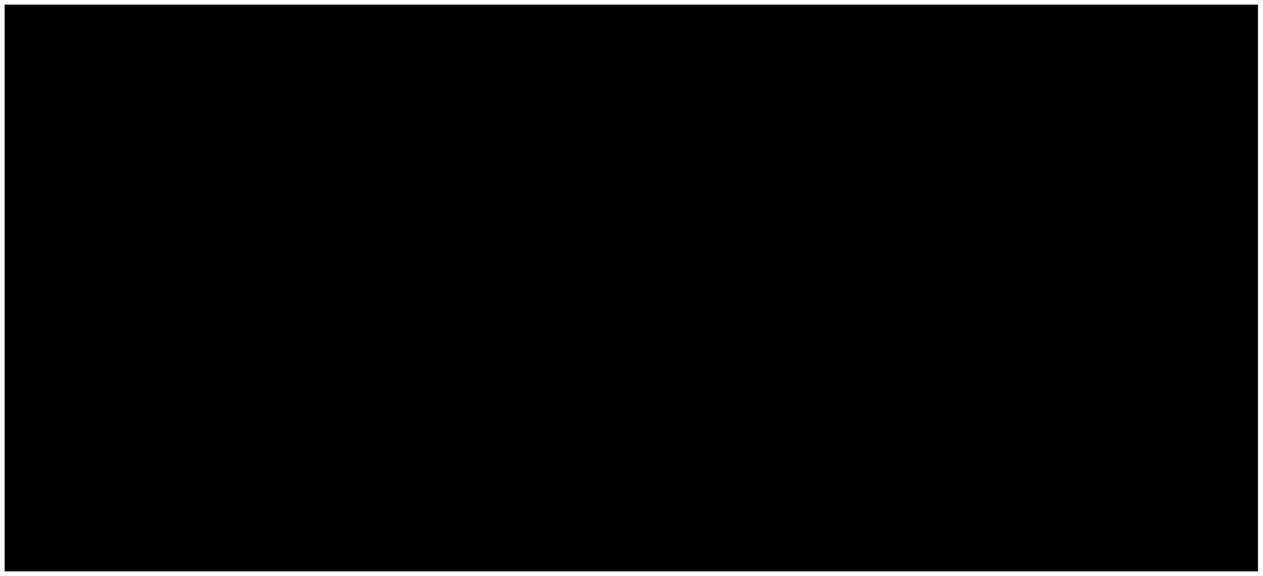
23) **Do you have a medical or physical condition that currently impairs your ability to practice medicine?** [redacted]

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

25) Domestic Violence and Sexual Violence Training Requirement

Have you completed training and education on the issue of domestic violence and sexual violence? Yes

[redacted]



Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

16) By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.

Physician Name: Cari E Brown, M.D. **License No.:** 263885

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cari E Brown, M.D. **License No.:** 263885

Current Status: Active **License Expiration Date:** 7/28/2016

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

[redacted]

Business Address:
Harvard Vanguard Medical Associates
40 Holland Street
Somerville
Massachusetts - 02144
United States of America
(215) 481-7824

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

4) **Fax Number:** (215) 481-2048

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
None Reported			

7) **Drug License Numbers**

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

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

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
Harvard Vanguard- Somerville	
Mount Auburn Hospital	

Physician Name: Cari E Brown, M.D. **License No.:** 263885

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

12) Medical Liability Insurance Information

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

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

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

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

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

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

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

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

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

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

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

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

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

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital that has a CMS Meaningful Use program.

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

[redacted]

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cari E Brown, M.D. **License No.:** 263885

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.

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15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Cari E Brown, M.D. **License No.:** 263885

Current Status: Active **License Expiration Date:** 7/28/2018

1) **Activity Status:** Active

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Mailing Address:

Home Address:

[redacted]

Business Address:
Harvard Vanguard Medical Associates
40 Holland Street
Somerville
Massachusetts - 02144
United States of America
(215) 481-7824

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

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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ABMS/AOA	Board Name	Certification	Subspecialty
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9) **States where you were previously licensed**
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WorkSite	Location
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Mount Auburn Hospital	

Physician Name: Cari E Brown, M.D. **License No.:** 263885

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b) outpatient care 24 hrs/wk

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Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2018	12/31/2018	Claims made with tail coverage

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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 condition that interferes in any way or limits your ability to practice medicine?** [redacted]

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

25) MassHealth Enrollment Status
I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider.

Physician Name: Cari E Brown, M.D. **License No.:** 263885

[redacted]

[redacted]

Compliance with Legal Responsibilities

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Physician Name: Cari E Brown, M.D. **License No.:** 263885

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☒ **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.**