

LAPSED SUPPLEMENT INSTRUCTIONS

The following instructions will help you answer Questions 1-14. If you answer “yes” to any of these questions, you must also fill out the supplemental pages. Read these instructions and the supplemental pages carefully. Your application may be delayed if you fail to provide all the information requested.

This portion of the application is not a public record, and is held as confidential information unless you expressly authorize the Board to release it to a particular party. Under the law, the Board may also share this information with legally designated agencies, such as other state licensing boards and law enforcement agencies. Designated agencies are required to maintain the confidentiality of this information consistent with the law.

1-A. Medical license application withdrawal or denial of medical license: You should answer "yes" if you withdrew your application after learning that your license application probably would not be approved or would be approved only with conditions or restrictions. You do not need to answer “yes” if you withdrew your application solely because of a decision to relocate that was entirely unrelated to anticipated rejection of your application, or if you let your license lapse because you no longer practice medicine in that jurisdiction.

1-B. Voluntary surrender of license: You must report any surrender of a license to a licensing board or other governmental agency. You do not need to answer “yes” to this question if you let your license lapse because you no longer practice medicine in that jurisdiction.

3-A, and 3-B. Disciplinary action: A confidentiality agreement does not absolve you of your requirement to answer Question 3-A or 3-B. If you answer “Yes” you must also complete the supplement.

For the purpose of answering Questions 3-A or 3-B, the terms listed below have the following meanings:

An “investigation” is any inquiry conducted by a private or governmental authority concerning you.

This question includes, but is not limited to, investigations, reviews, and inquiries conducted by: hospitals, clinics, nursing homes, health insurers, medical malpractice insurers, professional associations, federal agencies, and state agencies. This question includes investigations, reviews, and inquiries conducted by the Massachusetts Board of Registration in Medicine and its sub-Committees, including the Data Repository Committee and the Complaint Committee.

You do not need to report investigations of an entire facility or department. For example, an annual departmental review of complication rates is not a reportable investigation within the meaning of this question because your activities have not been singled out for review.

A “governmental authority” refers to any federal, state, county, or municipal governmental entity, including but not limited to: any medical licensing board (including Massachusetts), any agency regulating health care quality, any medical assistance authority, any regulatory authority investigating insurance fraud, and any agency that regulates the possession, dispensing, and prescribing of any controlled substances.

A “health care facility” refers to any hospital (including federal, state, county, and municipal hospitals), clinic, prison infirmary, home for unwed mothers, nursing home, or health maintenance organization. For the purpose of this question, a health care facility includes a post-graduate training program.

“Group practice” refers to any association of healthcare professionals organized for the delivery of patient care of which you are a member or partner or by which you are employed or with which you have a contract for professional services, including a partnership or limited liability partnership, limited liability company, professional corporation, or other professional business organization.

“Disciplinary action,” as defined in the Board’s regulations, is an action which adversely affects a licensee. The action can be formal or informal, oral or written, and voluntary or involuntary.

Disciplinary actions that are always reportable to the Board include, but are not limited to, the following or their substantial equivalents: revocation of a right or privilege, suspension of a right or privilege, censure, written reprimand or admonition, fines, and required performance of public service.

Disciplinary actions that are sometimes reportable to the Board include, but are not limited to, the following or their substantial equivalents: restriction of a right or privilege, non-renewal of a right or privilege, denial of a right or privilege, resignation, leave of absence, withdrawal of an application, and termination or non-renewal of a contract. These actions are reportable to the Board if they arose, directly or indirectly, from the licensee’s competence to practice medicine, or from a complaint or allegation regarding any violation of law, regulation, or bylaw.

For example, non-renewal of a medical license in another state based on the licensee’s cessation of practice there is not a disciplinary action.

For example, a leave of absence taken for family reasons or for illness is not a disciplinary action.

For example, termination or non-renewal of an employment contract due to relocation is not a disciplinary action.

A course of education, training, counseling or monitoring is reportable to the Board as a disciplinary action only if it arose out of the filing of a complaint or other formal charges reflecting on the licensee’s competence to practice.

4-A, 4-B, 4-C, and 4-D. Medical staff membership, status and privileges: You must answer these questions about your medical staff status at any health care facility at which you have ever had membership or privileges. You do not need to include information about your tenure at health care facilities as a medical student or resident.

5. Criminal proceedings: Being “charged with a criminal offense” includes being arrested, arraigned or indicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. You must also report: convictions for felonies and misdemeanors; *nolo contendere* pleas; matters where sufficient facts of guilt were found; matters that were continued without a finding even if they were ultimately dismissed; and any other plea bargain. A medical malpractice claim is a civil, not a criminal, matter. A charge of Driving Under the Influence is not a “minor traffic offense” and should be reported.

6. Controlled substances privileges: You do not need to answer "yes" if you permitted your state and/or federal license(s) to expire solely because you decided to relocate and your decision to relocate was entirely unrelated to allegations of wrongful or otherwise irregular prescription practices.

7, 8 and 9. Medicare, Medicaid and third party payors: If you have been restricted from participation in a state or federally funded health care plan or third party plan or if your membership has been terminated, you must answer “yes.”

10-A. Malpractice claims: You must report all malpractice claims, whether or not they resulted in lawsuits and whether they are pending or have been resolved. You must answer “yes” even if you were named in a case or claim and subsequently dropped from it or the case or claim was dismissed with no finding against you or payment made on your behalf. You must report all cases or claims filed or heard in any state.

10-B. Non-malpractice lawsuits: You must report certain lawsuits filed against you even if they do not allege malpractice. Examples include, but are not limited to, lawsuits filed under consumer protection, antitrust, civil rights, fraud, or intentional tort (e.g. libel, interference with contractual relations) laws. You must report only those suits relating to your competency to practice medicine or your professional conduct in the practice of medicine.

11-A and 11-B. Medical condition: “Medical condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, hearing and memory impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cerebrovascular disease, cognitive disorders, cancer, heart disease, diabetes, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

“Ability to practice medicine” is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments and learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“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.

12-A and 12-B. Use of Chemical Substances: “Chemical substances” is to be construed to include alcohol, drugs or medications, including those drugs or medications (controlled substances) taken pursuant to a valid prescription for legitimate medical purposes and in accordance with this direction, as well as those used illegally. Illegal use of controlled substances includes use of substances obtained illegally (for example, heroin or cocaine) as well as the use of substances in an illegal manner (for example, use of prescription drugs which are obtained without a valid prescription or taken not in accordance with the directions of a licensed health care practitioner).

13. Illegal use of drugs: See definitions above.

You have a right to elect not to answer the above question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of the Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment privilege, you must do so in writing. Your full license application will be processed if you claim the privilege.

14. Voluntary modification of scope of practice: Describe any voluntary modification of or limitation to your scope of practice not covered by Questions 11-A and 11-B, and the reasons for it.

A Note to the Physician who is Chemically Dependent

If you are chemically dependent, the Board encourages you to seek assistance voluntarily. When the Board receives notice of impairment or dependency, its policy is to protect the public but also to ensure rehabilitation through the physician's participation in approved treatment programs and supervised, structured aftercare. The Board's Chemically Dependent Physician Policy relies on cooperation between the Board and groups like the Massachusetts Medical Society's Physician Health Services to ensure successful rehabilitation.

PLEASE NOTE: If you answered “yes” to any of Questions 1-14, you must also fill out the supplemental pages.

SUPPLEMENT FORM FOR LAPSED APPLICATION

PRINT NAME: _____ DATE: ____/____/____

IMPORTANT NOTE: If you answer “yes” to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS

YES NO

- | | | |
|--|--------------------------|--------------------------|
| 1-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 1-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3-A. 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). | <input type="checkbox"/> | <input type="checkbox"/> |
| 3-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4-A. Have you ever voluntarily relinquished any medical staff membership? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4-B. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4-C. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been charged with any criminal offense, other than a minor traffic offense? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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? | <input type="checkbox"/> | <input type="checkbox"/> |

Signed: _____

Date: _____

YES **NO**

- 7. Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?

- 8. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?

- 9. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

- 10-A. 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?

- 10-B. In the past ten (10) years, 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?

Applicant's Signature: _____ Date: ____/____/____

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 supplement pages for questions #11-A to 14. 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 of this application.

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 11-A. 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 to function as a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11-B. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12-A. 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 impaired or limited? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12-B. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. 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? | <input type="checkbox"/> | <input type="checkbox"/> |

If your responses to Questions 1-14 change while your lapsed application is pending, you must immediately notify the Board of the new information.

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

I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

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

Applicant’s Signature: _____ Date: ____/____/____

QUESTIONS #1-A & 1-B – License application withdrawal, denial or license surrender

Attach additional pages with same format where necessary.

Describe circumstances under which license application was withdrawn or denied, or license was voluntarily surrendered.

State: _____ Year: ____/____/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding the withdrawal, denial or voluntary surrender directly to the Board. Such documentation must specify the reason(s) for denial, withdrawal of your license application or voluntary surrender of your license.

QUESTION #2 – Lost or denied American Board of Medical Specialties certification

Specialty Board: _____ **Date of action:** ____/____/____

Explain reason(s) for loss or denial: _____

QUESTIONS #3-A & 3-B – Disciplinary actions

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action: _____ Date: ____/____/____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.

Signature: _____ Date: ____/____/____

PRINT NAME: _____

QUESTIONS #4-A, 4-B, 4-C, and 4-D – Medical staff membership, status and/or privileges

Attach additional pages with same format where necessary. Describe circumstances leading to change in medical staff membership, status and privileges:

Name of facility: _____ Date of action : ____/____/____
Address: _____ City: _____ State: ____ Zip: _____
Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 4-A through 4-D directly the Board.

QUESTION #5 – Criminal proceedings

Attach additional pages with same format if more than one charge and where otherwise necessary.

Court: _____ Charge: _____ Date: ____/____/____
____/____/____

Please attach a detailed account of circumstances leading up to criminal proceedings.

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant directly to the Board.

Signature: _____ Date: ____/____/____

Print Name: _____

QUESTION #6 – Controlled substances privileges

Attach additional pages with same format where necessary.

Type of restriction: _____ Date: ____/____/____

Circumstances of Restriction:

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact and correspondence related to any affirmative response directly to the Board.

QUESTIONS #7, 8 and 9 – Liability insurance and provider restrictions, denial, and revocation

Name of organization: _____ Date of
action: ____/____/____

Action: _____

Explain reason(s) for action:

Signature: _____ Date: ____/____/____

Print Name: _____

QUESTIONS #10-A & 10-B – Malpractice claims and other lawsuits

You must provide the following information on this form for each instance of alleged malpractice. You may photocopy this form and attach additional copies, if necessary. Please type or print. You must also complete the back of this form.

Claimant’s Name: _____ Date of incident: ___/___/___

Insurer’s name: _____

Insurer’s Address: _____

Description of alleged basis (es) of claim (allegations only: this does not constitute an admission of fault or liability). See Table 5 attached. Basis codes must be completed.

Allegation _____ Allegation _____ Allegation _____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient’s condition at point of your involvement: _____

2. Patient’s condition at end of treatment: _____

3. The nature and extent of your involvement with the patient: _____

4. Your degree of responsibility for the course of treatment leading to the claim: _____

5. If incident resulted in patient’s death, indicate cause of death according to autopsy or patient chart: _____

Incident location (check one):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 01 Emergency Room | <input type="checkbox"/> 02 Labor/Delivery | <input type="checkbox"/> 03 Laboratory/X-ray/Testing | <input type="checkbox"/> 04 Operating Room |
| <input type="checkbox"/> 05 Outpatient | <input type="checkbox"/> 06 Patient Room | <input type="checkbox"/> 07 Hospital-Other | <input type="checkbox"/> 08 Hospital-Unknown |
| <input type="checkbox"/> 09 HMO | <input type="checkbox"/> 10 Clinic | <input type="checkbox"/> 11 Nursing Home | <input type="checkbox"/> 12 Physician’s Office |
| <input type="checkbox"/> 13 Walk-in Center | <input type="checkbox"/> 14 Other | <input type="checkbox"/> 15 Unknown | |

Your role (check one):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 01 Anesthesiologist | <input type="checkbox"/> 02 Primary Care Physician | <input type="checkbox"/> 03 Referring Physician | <input type="checkbox"/> 04 Attending Physician |
| <input type="checkbox"/> 05 Consultant Specialist | <input type="checkbox"/> 06 Surgeon | <input type="checkbox"/> 07 Fellow | <input type="checkbox"/> 08 PGY 7 |
| <input type="checkbox"/> 09 PGY 6 | <input type="checkbox"/> 10 PGY 5 | <input type="checkbox"/> 11 PGY 4 | <input type="checkbox"/> 12 PGY 3 |
| <input type="checkbox"/> 13 PGY 2 | <input type="checkbox"/> 14 PGY 1 | <input type="checkbox"/> 22 Acupuncturist | <input type="checkbox"/> 26 On-call Physician |
| <input type="checkbox"/> 27 Worker’s Comp
Evaluator | <input type="checkbox"/> 28 Court Psychiatrist | <input type="checkbox"/> 24 Group Practitioner/Partner | <input type="checkbox"/> 99 Unknown |
| | <input type="checkbox"/> 98 Other | | |

Signature: _____

Date: ____/____/____

(Continued on next page)

QUESTION #10-A & 10-B, - Malpractice claims & other lawsuits, continued...

Legal Representative's Name:

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

- If a medical malpractice tribunal has heard your case, indicate the following:
 Finding for: You Plaintiff Date: ____/____/____
- If the Court has heard your case, indicate the following:
 Decision determined by (check one): Judge Jury
 Decision: _____ Award: _____
- If your case was appealed, indicate the following:
 Date appeal was filed: ____/____/____ Date appeal was decided: ____/____/____
- If your case was settled, indicate the following:
 Date of settlement: ____/____/____ Total settlement amount: \$ _____
 Amount of settlement paid on your behalf: \$ _____
- Was the case dismissed against you? Yes No Against all defendants? Yes No

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

Signature: _____

Date: ____/____/____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #11-A and 11-B – Medical condition

If you answered “yes” to Questions 11-A or 11-B, please set forth the specifics of your condition and any related treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than three (3) months prior to the date of your application. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

QUESTION #12-A – Use of chemical substances

If you have obtained medical treatment related to your use of chemical substances, set forth the specifics of your treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of chemical substances on your current practice, including participation in any supervised rehabilitation program or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than thirty (30) days prior to the date of your application. You must also arrange for the appropriate institutions to submit all discharge summaries regarding any alcohol or drug dependency directly to the Board. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

Signature: _____

Date: ____/____/____

PRINT NAME: _____

QUESTION #12-B – Refusal to take screening test

If you answered “yes” to Question #12-B, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

QUESTION #13 – Illegal use or misuse of drugs

List chemical substances:

Describe frequency of usage:

Please note that additional information may be requested by the Board.

QUESTION #14 – Voluntary modification of scope of practice

Describe circumstances leading to modification of practice:

Describe modification of practice _____

Dates: From: ____/____/____ To: ____/____/____

Please note that additional information may be requested by the Board.

Signature: _____

Date: ____/____/____

TABLE 5: BASIS FOR ALLEGATION**ABUSE OF (PATIENTS, EMPLOYEE(S)/PEER(S)**

Abuse of Employee(s) /Peer(s) - Physical
Abuse of Patient(s) - Physical
 Sexual misconduct
 Sexual misconduct - Verbal

ADMINISTRATIVE PROBLEMS

Academic research fraud
 Billing for services not rendered
 Billing fraud (not Medicaid/Medicare)
 Breach of confidentiality
 False or deceptive advertising
 Inadequate documentation/patient records
 Insurance balance billing (not Medicaid/Medicare)
 Medicaid/Medicare
 Medicaid/Medicare balance billing

SUPERVISION

Fully licensed physician
 Limited licensee (e.g. resident)
 Nurse or other employee
 Physician's assistant

DIAGNOSIS RELATED

Delay in diagnosis
Failure to Diagnose
 Abdominal problems (not appendicitis or ulcer)
 AIDS/AIDS Related Complex/HIV
 Appendicitis
 Bladder problem
 Bone cancer
 Bowel problem
 Breast cancer
 Cancer (unspecified)
 Cardiac disorder (not myocardial infarction)
 Circulatory problem
 Colon/rectal cancer
 Diabetes
 Eye disorder
 Fracture/Dislocation
 Gall Bladder disorder
 Genetic disorder
 Hemorrhage
 Hernia
 Hodgkin's disease
 Implanted foreign body
 Infection
 Kidney disorder
 Liver disorder
 Liver/kidney/pancreas cancer
 Lung cancer
 Lyme disease
 Meningitis
 Myocardial infarction
 Neurological disorder
 Orthopedic problem (not fracture/dislocation)
 Ovarian/cervical cancer
 Pneumonia/pneumothorax
 Respiratory problem
 Skin cancer
 Tendon injury
 Testicular torsion
 Testicular/prostate cancer
 Tumor
 Ulcer or complication(s) of ulcer
 Failure to perform diagnostic test(s)
 Lack of informed consent
 Misdiagnosis
 Ordering/performing unnecessary diagnostic tests/procedures

BIOMEDICAL EQUIPMENT/PRODUCT RELATED

Malfunction
 Misuse

TREATMENT RELATED

Abandonment of patient
 Delay in treatment
 Failure to make referrals appropriately
 Failure to monitor patient
 Failure to notify patient of test results
 Failure to take adequate patient history
 Failure to treat
 Failure to use consultants appropriately
 Improper choice of treatment
 Improper treatment of fracture/dislocation
 Inappropriate admissions(s)
 Inappropriate discharge(s)/transfer(s)
 Lack of informed consent

Anesthesia Related

General
 Allergic/adverse reaction
 Failure to test improper use of equipment
 Improper intubation
 Improper positioning of patient
 Lack of informed consent
 Teeth damage
 Wrong amount/type of anesthesia prescribed

Intravenous Related

CVP line
 Dye reaction
 General
 Infiltration
 Lack of informed consent

Medication Related

Drug side effect
 Drug toxicity/overdose
 Failure to diagnose drug addiction
 Failure to diagnose drug related problem(s) (not addiction)
 Failure to prescribe
 General
 Lack of informed consent
 Prescribing to a known addict
 Wrong dose of medication ordered/administered
 Wrong medication ordered/administered

Mental Illness Related

Failure to diagnose mental disorder/illness/problem
 Failure to warn third party(ies)
 General
 Improper commitment
 Improper use of seclusion/restraints
 Lack of informed consent
 Suicide/suicide attempt by inpatient
 Suicide/suicide attempt by outpatient

Obstetrics-Gynecology Related

Failed sterilization
 Failure to diagnose ectopic pregnancy
 Failure to diagnose Pregnancy, normal
 Fetal death/stillbirth
 Gynecology-general
 Improper performance of abortion
 Injury to child during labor/delivery
 Injury to mother during labor/delivery
 Lack of informed consent
 Maternal death related to delivery
 Obstetrics-general
 Wrongful life/birth

Surgery Related

Delay in surgery
 General
 Failure to diagnose post-op complications
 Improper treatment of post-op complication
 Improper/negligent performance
 Laceration/penetration not within scope of surgery
 Lack of informed consent
 Positioning-not anesthesia
 Retained foreign bodies (e.g. needle, sponge)
 Unnecessary surgery
 Wrong body part or wrong patient

Specified Procedures/Specialties

Angiography/arteriography
 Biopsy
 CAT scan/MRI
 Catheterization
 Chemotherapy
 Circumcision
 Colonoscopy
 Endoscopy
 Injection/Immunization
 Laparoscopy/laparotomy
 Myelography
 Neonatology
 Neurology
 Orthopedics
 Pediatrics
 Plastic/cosmetic surgery
 Radiation therapy
 Stress test
 Suturing

TRANSFUSION RELATED

Caused AIDS/HIV
 Caused hepatitis
 Mismatch

MISCELLANEOUS

Improper utilization review
 Improper Workmen's Compensation evaluation
 Patient fall (in health care facility/office)
 Performance of autopsy without permission
 Unauthorized DNR order
 Vicarious liability for acts of another provider
 Violation of patient's civil rights
 Wrongful death of patient