MT198973

SPOA 1415 (1/10)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-1400 or 717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

HOSPITAL USE ONLY

TO BE COMPLETED FOR BULK CHECK USAGE

Hospital Name: York Hospital
HS # 000365L
Receipt # 5614736

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

253510

Application Fee: $30.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania." Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

TO BE COMPLETED BY APPLICANT: (Please Print or Type)

NAME: Bina (First) Brandi (Middle) Nicole

ADDRESS: [redacted]

Dorchester (City) MA (State) 02125 (Zip Code)

SOCIAL SECURITY #: [redacted] DATE OF BIRTH: [redacted] (MM/DD/YYYY)

If your medical/licensure records are listed under another name or names, please list below:

Are you applying using credentials verification from FCVS? ☐ YES ☒ NO

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
Boston University 8 SE Concord St, Boston MA 02118	8/2007 - 5/2011	5/21/2011
NAME & ADDRESS OF HOSPITAL(S)	**DATES OF PREVIOUS TRAINING**	**SPECIALTY**

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: MEDICAL EDUCATION YORK HOSPITAL HS-- 000365-L

ADDRESS OF HOSPITAL: 1001 SOUTH GEORGE STREET YORK, PA 17405

YEAR IN TRAINING: 1 (CL ACGME) SPECIALTY: Ob/Gyn LEVEL IN TRAINING (PGY) 1

DATES OF TRAINING REQUESTED: June 24, 2011 (BEGINNING DATE-(MM/DD/YYYY)) TO June 23, 2012 (ENDING DATE-(MM/DD/YYYY))

I VERIFY THAT I AM THE PROGRAM DIRECTOR FOR THE HOSPITAL PROGRAM LISTED ABOVE AND THAT THIS IS AN ACGME ACCREDITED PROGRAM AT THIS HOSPITAL.

NAME OF PROGRAM DIRECTOR:

SIGNATURE OF PROGRAM DIRECTOR: Richard W. Sloan, Jr. Richard W. Sloan, M

SPOA 1415 (1/10)

Answer the following questions. If "YES" is answered to Questions #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? If yes, list the jurisdiction(s) here: _____.		✓
2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		✓
3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		✓
4) Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		✓
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**	[redacted]	
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number**, **filing date**, and the **date you were served**.		✓

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted]

SIGNATURE OF APPLICANT

3/21/2011

DATE

State Board of Medicine
717-783-1400
717-787-2381

RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: Ring (Last) Brandi (First) Nicole (Middle)

Name of medical school: Boston University

Location: 85 E. Concord St, Boston MA 02118

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: Brandi N Ring

Date student began to attend this medical school: 08/13/2007 (MM/DD/YYYY)

Date of graduation: 05/22/2011 (MM/DD/YYYY)

APR 01 2011

I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar: Ellen J DiBine

Date: 3/30/11

This form may be completed ONLY three months prior to graduation. Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope. ***If graduation DOES NOT take place, notify the Board immediately***

DO NOT RETURN TO APPLICANT

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 22, 2011

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: April 22, 2011
Your Reference Number: BLONG
FSMB Batch Number: BQ1899007

The following is a report of the search results from the Board Action Data Bank as of April 22, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 22, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
4	OWINGS, VALERIE	[redacted]		2011	23675670
		LICENSE HISTORY State Board No License Information Available			
3	PACKER, NICHOLAS	[redacted]		2011	23675669
		LICENSE HISTORY State Board No License Information Available			
2	PHILLIPS, SHAWN	[redacted]		2011	23675660
		LICENSE HISTORY State Board No License Information Available			
1	RING, BRANDI	[redacted]		2011	23675648
		LICENSE HISTORY State Board No License Information Available			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT198973
RING

RENEWAL APPLICATION

Receipt #6073466

BRANDI NICOLE RING 9849
YORK HOSPITAL
JULIE UNGER
MEDICAL EDUCATION
1001 SOUTH GEORGE STREET
YORK PA 17405

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☐ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	✓	2. **Since your initial application or your last renewal, whichever is later,** have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	✓	3. **Since your initial application or your last renewal, whichever is later,** have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	✓	4. **Since your initial application or your last renewal, whichever is later,** have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	5. **Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?**
	✓	6. **Since your initial application or your last renewal, whichever is later,** have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. **Since your initial application or your last renewal, whichever is later,** have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. **Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.**

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/24/2011	6/23/2012	Level 1	Obstetrics and Gynecology	HS000265L	YORK HOSPITAL
Renewal	6/24/2012	6/23/2013	2	Ob/Gyn	HS000265L	York Hospital

Signature of Licensee (Mandatory) [redacted] Date: 4/11/2012

Medical School Graduation Date: 5/19/2011 SSN: [redacted]

ATTACHMENTS FOR RENEWING:

- **FEE** – $15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for a returned payment.
- **LATE FEE** - $5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT** – Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree, etc.)
- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** – Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1, 2 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

RECEIVED
APR 19 2012
By

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Date: 10/04/2010

Examinee: Ring, Brandi Nicole

Examinee ID: 5-232-396-1
Date of Birth: [redacted]

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE Step 1

		Three-Digit Score		Two-Digit Score		
Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
05/21/2009	Fail	182	(185)	74	(75)	
09/05/2009	Pass	199	(185)	81	(75)	

USMLE Step 2

Clinical Knowledge (CK)

		Three-Digit Score		Two-Digit Score		
Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
07/01/2010	Pass	194	(189)	78	(75)	

Clinical Skills (CS)*

Test Date	**Pass/Fail**	**Comments**
06/10/2010	Pass	

*Performance on the CS component of Step 2 is reported as pass or fail.

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT198973
RING

RENEWAL APPLICATION

Receipt # 6624370

BRANDI NICOLE RING 9849
YORK HOSPITAL
JULIE UNGER
MEDICAL EDUCATION
1001 SOUTH GEORGE STREET
YORK PA 17405

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☐ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
	✓	2. **Since your initial application or your last renewal, whichever is later,** have you ever had disciplinary action taken against your license, certification, or registration issued to you in any profession in any other state or jurisdiction?
	✓	3. **Since your initial application or your last renewal, whichever is later,** have you withdrawn an application for a license, certification, or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?
	✓	4. **Since your initial application or your last renewal, whichever is later,** have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	5. **Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?**
	✓	6. **Since your initial application or your last renewal, whichever is later,** have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. **Since your initial application or your last renewal, whichever is later,** have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. **Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served.** If the Civil Complaint was previously submitted, provide a statement, which lists the docket number.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/24/2012	6/23/2013	Level 2	Obstetrics and Gynecology	HS000265L	YORK HOSPITAL
Renewal	6/24/2013	6/23/2014	3	Ob/Gyn	HS000265L	York Hospital

Signature of Licensee (**Mandatory**): [redacted] Date: 4/2/2013

Medical School Graduation Date: May 2011 SSN: [redacted]

ATTACHMENTS FOR RENEWING:

- **FEE** – $15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for a returned payment.
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- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
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USMLE
United States
Medical
Licensing
Examination

UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 3 SCORE REPORT

This score report is provided for the use of the examinee.
Third-party users of USMLE information are advised to rely solely on official USMLE transcripts.

Ring, Brandi Nicole

USMLE ID: 5-232-396-1

Test Date: June 12, 2012

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.

208	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 219 and 17, respectively, with most scores falling between 140 and 260. A score of 190 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately seven points.

79	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 190 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately two points.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT198973
RING

RENEWAL APPLICATION

Receipt # 7073592

BRANDI NICOLE RING ~~9649~~
YORK HOSPITAL
JULIE UNGER
MEDICAL EDUCATION
1001 SOUTH GEORGE STREET
YORK PA 17405

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

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THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice this profession in any other state or jurisdiction? List:
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Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/24/2013	06/23/2014	Level 3	Obstetrics and Gynecology	HS000265L	YORK HOSPITAL
Renewal	6/24/2014	6/23/2015	4	OB/GYN	HS000265Z	York Hospital

Signature of Licensee (**Mandatory**): [redacted] Date: 4/16/14

Medical School Graduation Date: 5/2011

SSN [redacted]

ATTACHMENTS FOR RENEWING:

- **FEE** – $15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for a returned payment.
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APR 24 2014

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Date: 10/04/2010

Examinee: Ring, Brandi Nicole

Examinee ID: 5-232-396-1
Date of Birth: [redacted]

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE Step 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
05/21/2009	Fail	182	(185)	74	(75)	
09/05/2009	Pass	199	(185)	81	(75)	

USMLE Step 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
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Clinical Skills (CS)*

Test Date	Pass/Fail	Comments
06/10/2010	Pass	

*Performance on the CS component of Step 2 is reported as pass or fail.

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

USMLE
United States
Medical
Licensing
Examination

UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 3 SCORE REPORT

This score report is provided for the use of the examinee.
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Ring, Brandi Nicole
USMLE ID: 5-232-396-1

Test Date: June 12, 2012

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 3 is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.

208	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 219 and 17, respectively, with most scores falling between 140 and 260. A score of 190 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately seven points.

79	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 190 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately two points.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

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

03/01/2015

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:	Ring, Brandi
LICENSE TYPE:	Graduate Medical Trainee
LICENSE #:	MT198973
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	04/22/2011
LICENSE EXPIRATION DATE:	06/23/2015
DISCIPLINARY HISTORY:	NO Disciplinary Action Exists

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT198973
RING

RENEWAL APPLICATION

BRANDI NICOLE RING [redacted]
YORK HOSPITAL
JULIE UNGER
MEDICAL EDUCATION
1001 SOUTH GEORGE STREET
YORK PA 17405

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☑ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-13 - provide details AND attach certified copies of legal document(s).
	✓	1. Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** List:
	✓	2. **Since your initial application or your last renewal, whichever is later,** have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?
	✓	3. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?
	✓	4. **Since your initial application or last renewal, whichever is later,** have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?
	✓	5. **Since your initial application or last renewal, whichever is later,** have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
	✓	6. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?
	✓	7. **Since your initial application or your last renewal, whichever is later,** have you had your DEA registration denied, revoked or restricted?
	✓	8. **Since your initial application or your last renewal, whichever is later,** have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?
	✓	9. **Since your initial application or your last renewal, whichever is later,** have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?
	✓	10. **Since your initial application or your last renewal, whichever is later,** have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?
[redacted]		**Since your initial application or last renewal, whichever is later,** have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?
		If you answered "Yes" to question 11, are you currently participating in the Pennsylvania Professional Health Monitoring Program?
	✓	13. **Since your initial application or last renewal, whichever is later,** have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.**
		****If you previously reported the complaint to the Board, provide the docket number** _____

APR 13 2015

MT198973
RING

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	6/24/2014	6/23/2015	Level 4	Obstetrics and Gynecology	HS000265L	YORK HOSPITAL
Renewal						

Signature of Licensee (**Mandatory**): [redacted] Date: 4/2/2015

Medical School Graduation Date: 5/2011 SSN [redacted]

CONTINUING MEDICAL EDUCATION

SPECIAL NOTICE TO ALL HEALTH-RELATED LICENSEES AND FUNERAL DIRECTORS

ACT 31 OF 2014 – INITIAL TRAINING AND CONTINUING EDUCATION IN CHILD ABUSE RECOGNITION AND REPORTING REQUIREMENTS

The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services, is providing advance notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DPW-approved training in child abuse recognition and reporting requirements as a condition of licensure.

Additionally, EFFECTIVE WITH THE FIRST LICENSE RENEWAL AFTER JANUARY 1, 2015, all health-related licensees and funeral directors applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable board.

Details can be found at www.dos.state.pa.us/med. For a list of Board-approved providers, click the "Child Abuse CE Providers" link. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board.

ATTACHMENTS FOR RENEWING:

- **FEE** – $15.00 check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for a returned payment.
- **LATE FEE** - $5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after the expiration date.
- **NAME CHANGE DOCUMENT – Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree,** etc.)
- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- **PGY 3 LEVEL or above** – Copy of your USMLE Step 3 scores OR FLEX I and II scores OR National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your unrestricted license WHICH SHOWS THE CURRENT EXPIRATION DATE.

APR 13 2015

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MT198973
RING

RENEWAL APPLICATION

BRANDI NICOLE RING [redacted]
YORK HOSPITAL
JULIE UNGER
MEDICAL EDUCATION
1001 SOUTH GEORGE STREET
YORK PA 17405

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☑ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. YOU MUST SIGN, DATE AND RETURN THIS FORM.**

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- **PGY 2 LEVEL** – Copy of your USMLE Step 1 and 2 scores OR FLEX I scores OR National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
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APR 13 2015

(12/2014)

Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE P.O. BOX 2649 HARRISBURG, PA 17105-2649 717-783-1400/717-787-2381 Email; st-medicine@pa.gov	STATE BOARD OF MEDICINE 2601 NORTH THIRD STREET HARRISBURG, PA 17110

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS (SCHOOLS IN THE U.S. AND CANADA)

Submit the $35 fee, check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** **Check or money order must be in U.S. funds.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

TO BE COMPLETED BY APPLICANT
(Please print or type)

NAME:	Last: RING	First: BRANDI	Middle: NICOLE
ADDRESS:	Street: [redacted]		
City: York		State: PA	ZIP: 17403
DATE OF BIRTH:	Month / Day / Year: [redacted]	**SOCIAL SECURITY NUMBER:**	[redacted]
EMAIL ADDRESS:	[redacted]@gmail.com		
PHONE NUMBER:	[redacted]		

If your medical/licensure records are listed under another name or names, please list below:

APPLYING USING FCVS (FEDERATION CREDENTIAL VERIFICATION SERVICE):	☐ YES	☑ NO
HAVE YOU PREVIOUSLY HELD A PA MEDICAL TRAINING LICENSE?	☒ YES - LICENSE NO. MT198973	☐ NO

MAR 27 2015

(12/2014)

APPLICATION FOR UNRESTRICTED LICENSE - AMERICAN

NAME OF APPLICANT:	Last	First	Middle
	RING	BRANDI	NICOLE

NAME & ADDRESS OF MEDICAL SCHOOL

1. NAME OF MEDICAL SCHOOL:	BOSTON UNIVERSITY SOM													
ADDRESS OF SCHOOL:	72 E. Concord St Boston MA 02118													
DATE OF ATTENDANCE:	FROM	Month: 09	Day: 01	Year: 2007	TO	Month: 05	Day: 15	Year: 2011	DATE OF GRADUATION:	Month: 05	Day: 15	Year: 2011		
2. NAME OF MEDICAL SCHOOL:														
ADDRESS OF SCHOOL:														
DATE OF ATTENDANCE:	FROM	Month:	Day:	Year:	TO	Month:	Day:	Year:	DATE OF GRADUATION:	Month:	Day:	Year:		

EXAMINATION INFORMATION

CHECK LICENSING EXAMINATION(S) PASSED:		STATE WHERE TAKEN	DATE TAKEN	
	☐ FLEX		COMPONENT 1:	
			COMPONENT 2:	
	☐ NATIONAL BOARD	PART I:	PART II:	PART III:
	☒ USMLE	STEP 1: 5/2009 9/2009 Fail / Pass	STEP 2: 7/2010 6/2011 Pass / Pass	STEP 3: 6/2012 Pass
	☐ LMCC – CANADIAN			
	☐ STATE BOARD	INDICATE STATE WHERE TAKEN:		

ACGME POST GRADUATE TRAINING

		FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)
PGY 1 HOSPITAL:	York Hospital	6/23/2011	6/23/2012
PGY 2 - 4 HOSPITAL:	York Hospital	6/23/2012	6/23/2015
Other HOSPITAL:		FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)

IF YOU NEED TO LIST ADDITIONAL POST GRADUATE TRAINING, PLEASE MAKE COPIES OF THIS FORM.

(12/2014)

LEGAL QUESTIONS

You must answer the following questions. If you answer "YES" to #2 through #13, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? **If you answered yes, provide the profession and state or jurisdiction.** LIST: Graduate Medical Trainee PA	X	
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		X
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		X
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		X
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		X
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		X
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		X
8	Have you had your DEA registration denied, revoked or restricted?		X
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		X
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		X
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		X
12	If you answered "Yes" to question 11, are you currently participating in the Pennsylvania Professional Health Monitoring Program?		[redacted]
13	Have you been the subject of a civil malpractice lawsuit? **If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.** ****If you previously reported the complaint to the Board provide the docket number**		X

SIGNED STATEMENT

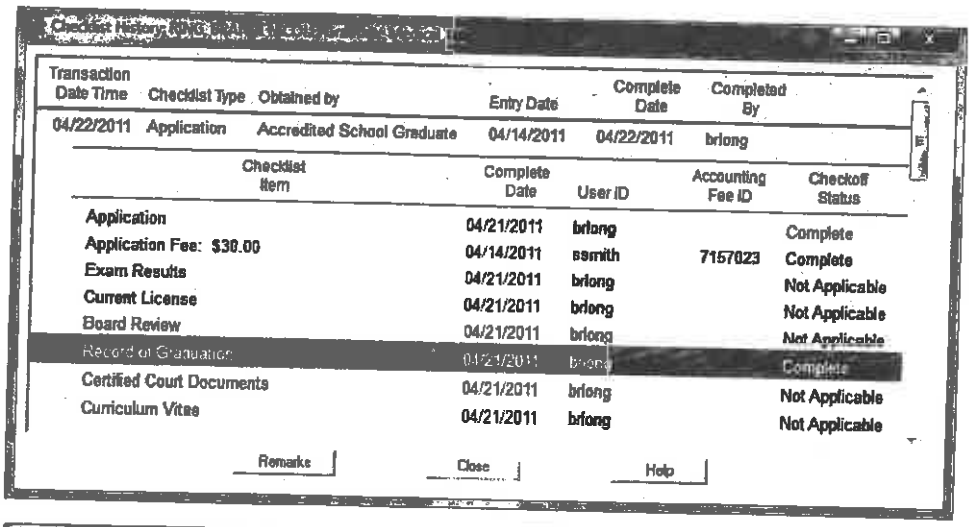
NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 8 Pa. C.S. Section 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

[redacted]
Signature of Applicant

2/28/15
Date

Brandi Bing
Printed Name of Applicant

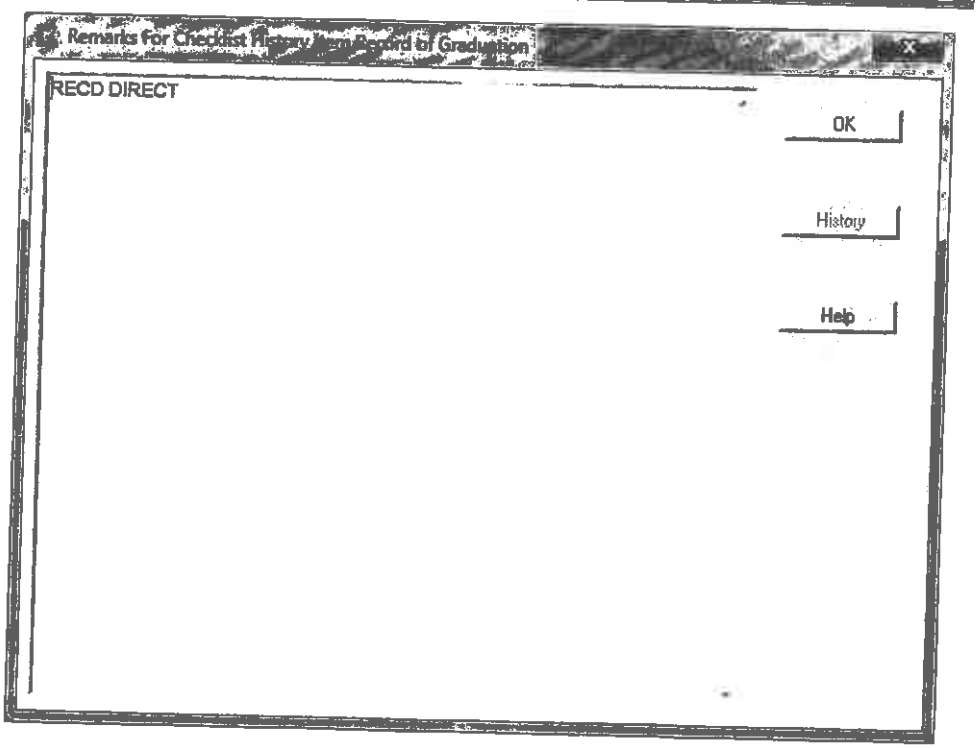


Transaction Date Time | Checklist Type | Obtained by | Entry Date | Complete Date | Completed By

04/22/2011 | Application | Accredited School Graduate | 04/14/2011 | 04/22/2011 | briong

Checklist Item	Complete Date	User ID	Accounting Fee ID	Checkoff Status
Application	04/21/2011	briong		Complete
Application Fee: $30.00	04/14/2011	ssmith	7157023	Complete
Exam Results	04/21/2011	briong		Not Applicable
Current License	04/21/2011	briong		Not Applicable
Board Review	04/21/2011	briong		Not Applicable
Record of Graduation	04/21/2011	briong		Complete
Certified Court Documents	04/21/2011	briong		Not Applicable
Curriculum Vitae	04/21/2011	briong		Not Applicable

Remarks | Close | Help



Remarks For Checklist History - Record of Graduation

RECD DIRECT

OK

History

Help

(12/2014)

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
(Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
	RING	[illegible]	MICHELE

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the thirty days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED:	WellSpan/York Hospital
NAME OF SPONSORING INSTITUTION:	WellSpan York Hospital
LOCATED IN: CITY	York
STATE	PA

PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	ACGME ACCREDITED Yes	No
1	06/24/2011	06/23/2012	OB/GYN	X	
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	Yes	No
2	06/24/2012	06/23/2013	OB/GYN	X	

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

Martha A. Tomas MD
Signature of Program Director

3/23/2015
Date

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Martha C. Tassia, Notary Public
City of York, York County
My Commission Expires Oct. 22, 2016
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES
(Seal)

Martha C Tassia
Notary Signature

Notary Commission Expiration Date: 10/22/2016

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

MAR 27 2015

383055

USMLE United States Medical Licensing Examination

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Date : 03/04/2015

Recipient:

Pennsylvania State Board of Medicine
ATTN: Michael Coates
2601 N Third Street
Harrisburg, PA 17110

Examinee: Ring, Brandi Nicole
Alt Name(s):

Examinee ID#: –5-232-396-1
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	09/05/2009	Pass	199	(185)	
	05/21/2009	Fail	182	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	07/01/2010	Pass	194	(189)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	06/10/2010	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
PENNSYLVANIA	06/12/2012	Pass	208	(190)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

RECEIVED DIRECT

MAR 0 4 2015

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

5500000095330268
Process Date: 03/01/2015
Page: 1 of 1

RING, BRANDI NICOLE - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: RING, BRANDI NICOLE
Date of Birth: [redacted]
Work Address: 1274 HILL ST, YORK, PA 17403-3309
Gender: FEMALE
Social Security Number: [redacted]
NPI: 1568754752
DEA: 2571594006O
License: PHYSICIAN RESIDENT (MD), MT198973, PA, OBSTETRICS & GYNECOLOGY
Professional School(s): BOSTON UNIVERSITY SCHOOL OF MEDICINE (2011)

B. PAYMENT INFORMATION

Credit Card Information: [redacted] (05/2016)
NPDB Charge: $10.00*
* Each charge will appear separately on your credit card statement.
NPDB Bill Reference Number: N36374932
Transaction Date: 03/01/2015
Additional Paper Copies Requested: 1

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 03/01/2015

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- **No Reports Found** ----------

MAR 27 2015

Curriculum Vitae

Brandi N. Ring, M.D.
[redacted]@gmail.com

Professional Experience

Clinical Research Coordinator May 2007 – August 2007
Boston Medical Center- Androgen Clinical Research Unit, Boston, MA

Clinical / Regulatory Associate / Clinical Trials Auditor June 2004 – July 2005
CBR International Corp. - Biotechnology Consulting Firm, Boulder, CO

Teaching Experience

Graduate Anatomy Teaching Assistant and Prosector October 2010
Medical Anatomy – Thorax, Abdomen and Pelvis

Graduate and Medical School Tutor August 2006 – Present
Subjects: Biochemistry, Physiology, Histology, Endocrinology

Graduate Teaching Assistant August 2006-December 2006
Boston University Medical School - Medical Histology

Education

York Hospital Obstetrics and Gynecology Residency June 2011 – Present
Categorical Resident Expected Graduation: June 2015

Boston University School of Medicine **M.D**
Medical Degree Program Graduation: May 2011
Honors: Obstetrics and Gynecology, Pediatrics, Surgery, Surgical Sub-Specialty, Teaching in Anatomy, Clinical Interviewing Skills, Surgical Sub-Internship
Awards: Gold Humanism Honor Society, BUSM Alumni-association Award

Boston University School of Medicine **M.A**
Graduate Medical Sciences Masters Graduation: May 2007
Thesis Title: *"Assessment of Physical Examination Skills in First Year Residents: Comparing Clinical Skills Knowledge and Performance with a Faculty Observed OSCE"*

Boston University School of Medicine **Certificate Program**
Clinical Investigation Expected Graduation: Jan 2014
Thesis Title: *"Assessment of Physical Exam Skills in First and Third Year Residents: Comparing Theoretical and Observed Competence During an OSCE Using Real Patients"*

University of Colorado at Boulder **B.A.**
Primary Major: Molecular, Cellular and Developmental Biology
Honors: Dean's List
Secondary Major: Environmental, Population and Organismic Biology
Honors: Dean's List
Minor: Biochemistry Graduation: May 2004

Certificate of Completion

Recognizing and Reporting Child Abuse:
Mandated and Permissive Reporting in Pennsylvania

Meets ACT 31 of 2014 training requirements

3 continuing education hours

Presenter:
University of Pittsburgh School of Social Work, PA Child Welfare Resource Center
403 East Winding Hill Road, Mechanicsburg, PA 17055

Presented to:
Ring, Brandi

on the date:
3/26/2015

MaryRose McCarthy, Director
PA Child Welfare Resource Center

Tracy Soska, Director of Continuing Education
School of Social Work

Provider Number: CACE000004

CE Course Number: PCW000001

MAR 27 2015

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: Pennsylvania State Board of Medicine As of Date:3/31/2015

PRACTITIONER INFORMATION

Name:	Brandi Nicole Ring
DOB:	[redacted]
Medical School:	Boston University School of Medicine Boston, Massachusetts, UNITED STATES
Year of Grad:	2011
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: Pennsylvania State Board of Medicine As of Date:3/31/2015

Practitioner Name: Brandi Nicole Ring

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

md

(12/2014)

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
(Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
	RING	BRANDI	NICOLE

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the thirty days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED:	WellSpan/York Hospital
NAME OF SPONSORING INSTITUTION:	WellSpan York Hospital
LOCATED IN: CITY	York
STATE	PA

PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	ACGME ACCREDITED Yes	No
1	06/24/2011	06/23/2012	OB/GYN	X	
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY	Yes	No
2	06/24/2012	06/23/2013	OB/GYN	X	

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

Mark A. Turner MD
Signature of Program Director

3/23/2015
Date

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Martha C. Tassin, Notary Public
City of York, York County
My Commission Expires Oct. 22, 2016
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Martha C Tassin
Notary Signature

Notary Commission Expiration Date: 10/22/2016

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

md

(12/2014) rb

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION

(For Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last: RING	First: BRANDI	Middle: NICOLE
NAME OF MEDICAL SCHOOL:	Boston University School of Medicine		
LOCATION:	Boston, MA		

Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

NAME OF MEDICAL SCHOOL:	Boston University School of Medicine		
NAME OF MEDICAL STUDENT:	Last: RING	First: BRANDI	Middle: NICOLE

	Month	Day	Year
DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:	08	13	2007
DATE OF GRADUATION:	05	22	2011

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

SIGNATURE OF DEAN/REGISTRAR: Ellen J. DeFiore

DATE:	Month	Day	Year
	03	27	2015

(Seal of School)

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN THIS FORM TO THE APPLICANT

Regular Mailing Address:
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address:
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MAR 3 1 2015

Boston University School of Medicine Transcript

Boston University School of Medicine
Office of the Registrar
72 East Concord Street
Boston, Massachusetts 02118

LAST NAME	FIRST	MIDDLE	I. D. NUMBER	DATE OF BIRTH	SEX
Ring	Brandi	N	*****1580	[redacted] YEAR	F

MATRICULATION DATE	DATE DEGREE AWARDED	HONORS	DEGREE PROGRAM
8/13/2007	5/22/2011		M.D.

ADMITTED FROM HIGH SCHOOL OR COLLEGE WITH DEGREES
University Of Colorado At Boulder BA 2004

TITLE		HRS.	GRADE
Curricular Year 1			
Biochemistry	(05-06)	120	AS
Endocrinology	(05-06)	33	AS
Essentials of Public Health I	(07-08)	60	Pass
Genetics	(07-08)	14	Pass
Gross Anatomy	(07-08)	170	Pass
Histology	(05-06)	79	AS
Human Behavior in Medicine	(07-08)	29	Pass
Immunology	(05-06)	16	AS
Neurosciences	(07-08)	98	Pass
Physiology	(05-06)	129	AS
Integrated Problems I-A	(07-08)	24	Pass
Integrated Problems I-B	(07-08)	35	Pass
Intro to Clinical Medicine I	(07-08)	84	Pass
		891	
Curricular Year 2			
Disease and Therapy 1	(08-09)	80	Pass
Disease and Therapy 2	(08-09)	80	Pass
Disease and Therapy 3	(08-09)	80	Pass
Disease and Therapy 4	(08-09)	80	Pass
Disease and Therapy 5	(08-09)	80	Pass
Disease and Therapy 6	(08-09)	80	Pass
Integrated Problems II-A	(08-09)	17	Pass
Integrated Problems II-B	(08-09)	17	Pass
Intro to Clinical Medicine II	(08-09)	102	Pass
		616	
Curricular Year 3			
Ambulatory Medicine	(09-10)	160	High Pass
Family Medicine	(09-10)	240	High Pass
Medicine	(09-10)	320	High Pass
Obstetrics and Gynecology	(09-10)	240	Honors
Pediatrics	(10-11)	240	Honors
Psychiatry	(09-10)	240	High Pass
Surgery	(09-10)	320	Honors
Surgery Subspecialty	(09-10)	160	Honors
		1920	

TITLE		HRS.	GRADE
Curricular Year 4			
Geriatrics/Home Medical Care	(10-11)	160	Pass
Neurology	(10-11)	160	Pass
Radiology	(10-11)	160	High Pass
Sub I - General Surgery	(10-11)	160	Honors
Subinternship Maternal-Fetal Medicine	(10-11)	160	High Pass
Electives			
Emergency Medicine Boston Medical Center-Menino Pavilion	(10-11)	160	Pass
Family Planning University of Colorado SOM	(10-11)	160	Honors
Family Planning and Reproductive Health Boston Medical Center	(10-11)	160	High Pass
Preparing Future Physician Educators: Learning How To Teach Clinical Interviewing Skills To First Year Students Boston University School of Medicine	(10-11)	80	Honors
Teaching in Anatomy Boston University School of Medicine	(10-11)	160	Honors
		1520	

Transcript Notes

End of Transcript

MAR 3 1 2015

REGISTRAR

BOSTON UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF THE REGISTRAR
GRADING SYSTEM

HONORS

HIGH PASS (available in third and fourth year courses only)

PASS

FAIL

INCOMPLETE

AS / H (ADVANCED STANDING with HONORS)

AS (ADVANCED STANDING)

EXEMPT

Effective January 1, 2008 all second year courses graded as Pass/Fail.

Effective September 8, 2003 all first year courses graded as Pass/Fail.

ADVANCED STANDING is granted to students who have satisfactorily completed the equivalent medical school course(s) at Boston University prior to matriculation to the School of Medicine.

EXEMPT status is granted to students who have satisfactorily completed the equivalent medical school course(s) outside of Boston University.

TRANSCRIPT NOTES:

ALTERNATIVE CURRICULUM is granted to first and / or second year students to extend their year(s) over a two year period.

DECELERATED CURRICULUM is a program for students who encounter academic difficulty during any of the curricular years.

MODIFIED CURRICULUM is granted to third and / or fourth year students to extend their year(s) over a two year period.

TRANSCRIPT REQUESTS

Official transcripts are issued only to other institutions, agencies, and employers at the written request of the student. They bear date of issue, signature of a responsible University official, the Boston University academic seal, and the background pattern. ACCEPT NO OTHER.

ACCREDITATION

Boston University is accredited by pertinent agencies in the educational fields which it serves.
Boston University as a whole is accredited by the New England Association of Schools and Colleges.
The School of Medicine is accredited by the Liaison Committee on Medical Education of the Association of American Medical Colleges.

Person Info
Name:BRANDI NICOLE RING
Address Info
Street Address [redacted]
Phone
Fax
City Denver
State CO
Zipcode 80207
Country 82
County Denver

Emai [redacted]@aol.com
[redacted]
3036680784

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction.	MD - Colorado
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
If you answer "No", please provide an explanation or reason for an exemption request.	No active practice in PA, active practice in Colorado
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	80246

Date Submitted: Sunday, January 15, 2017

Education Info

No education records

Employment Information