

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet. • Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes $C^{r} \notin \mathfrak{T}$ The Board will charge a fee for each copy. · Remit \$250.00 for renewal fee. · Return renewal application in GREEN envelope. · Add late fee of \$25.00, if necessary. · Enclose check with coupon in BLUE envelope. REDACTED COPY Renewal Date: 10/11/97 Registration No.: 80782 1. Activity Status: X Active ☐ Retiring (see instructions) 9 1997 ☐ Inactive *(see below) Do not wish to renew (Check only one) 2. Other Name(s), if any, under which you were licensed: Corrections (type-or print) Other Name(s): 3 A)Mailing/Business Address: GÍOVANNINA M ANTHONY, M.D. Mailing Address: City/Town: State: Country: B) Home Address: Other Address: City/Town: Home: Home Phone: Business: (Business Phone: (Date of Birth (M/D/Y): ___/_ Sex (M/F): ____ 4. A) Date of Birth: C) Sex: F Lic. Issue Date (M/D/Y): ___/_ /__ SS#:____ B) Lic. Issue Date: 02/22/95 D) SS#: Full Name of Medical School: 5. A) Name of Medical School: Univ. of Southern California School of Medicine B) Year Graduated: 92 C) Degree: MD Year Graduated: _____ Degree (MD/DO): 6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. Obstetrics and Gynecology If OS, Print Specialty: 7. Current American Board of Medical Specialties Certification (See Table 2) Code: Code: Code: Code: 8. Drug License Numbers, if any: Federal (DEA): A) Federal (DEA): Mass: B) Massachusetts: 9. A) Other states where you are now licensed to practice Abbr: CA OR MI PA B) States where you previously were licensed to practice

*If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts

Abbr:

Alexanura futhous MD 9/30/

Abbr:

PR	INT NAME AND NUMBER: Last Name: ANTHONY Registration Number:	40782
	A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Sup Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Facility Code:/ (AP)	ply the codes from
	B. Additional health care facilities at which you previously held privileges or with which you were associated in the past (See Table 3)	two (2) years.
	Facility Code: 92 Facility Code: 5 Facility Code: F	<u></u>
11.	If 999, write Name(s): My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit Name of Insurer: AMCCICAN Continental Insurance Co.	
	Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insural I am (check one) a) Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt Please explain exemption:	ance because
		Yes No
13.	A. What is your principal work setting? (See Table 4) 9 9 (vanable: locum lenens)	
	B. Care of patients in Massachusetts (see instruction booklet).	
	Average weekly hours involved in: a) outpatient carehrs/wk b) inpatient carehrs/w	k
	2) What is the approximate percentage of your patient care hours in primary care?%	
P/	ART A	
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each que ails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in	
	<u>Initions.</u>	
	THE PAST TWO (2) YEARS:	YES NO
IN		YES NO
IN 14. 15.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?	YES NO
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IN 14. 15. 16.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Ilas 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation?	YES NO
11. 14. 15. 16. 17. 18.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Ilas 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	YES NO
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11. 14. 15. 16. 17. 18. 19. 20.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason?	YES NO
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1N 14. 15. 16. 17. 18. 19. 20. 21.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Ilas 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Ilas your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?	YES NO
IN 14. 15. 16. 17. 18. 19. 20. 21.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Ilas 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Ilas your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? Have you completed your CME requirements preceding your renewal date (see instruction booklet)?	YES NO
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IN 14. 15. 16. 17. 18. 19. 20. 21.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? 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 been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? Have you completed your CME requirements preceding your renewal date (see instruction booklet)? Waiver requested (waiver form due 30 days prior to date of license expiration). Training Program exemption	SWERED.

GIOVANNINA First Name	M Middle Initial	ANT Initial Last 1		Suffi
Make changes to name here				
Mass License # 80782 License Status Active	/		First Issue Date	02/22/95
	Hospita	l Affiliation		
1A Garden Ct. #3 Boston, MA 02113-2034 U.S.A.	Brighan Massacl Clinic	n & Women's Hospit husetts General Hosp	al pital	
Make address corrections here:	Make any cor	rections to above here		
Insurance Plan Affiliation:	Licenses Held	Lin Other States:	Accepting New Patien	ts? Yes No
		•••••	Accept Medicaid?	□Yes □No
	(Please corre	ect as necessary)	<u></u>	
II. EDUCATION & TRAINING				
Univ. of Southern California School		MD	92 Date	
	De	gree	Date	
Residency Program(s)		Stari		End
Residency Program(s)		Start		End
II. <u>SPECIALTY</u>		BOARD CERTIFIC	CATION	
Primary Specialty: Obstetrics and Gy		Certifying Board Name		
Secondary Specialty:		Certifying Board Name	: :	
Make any corrections here:		Make any corrections i	here:	

Final Decisions and orders issued by the Ma	ssachusetts Board of Registration i	n Medicine.
<u>Nature</u>	<u>Date</u>	Board Action
HOSPITAL DISCIPLINE Hospital	Date	Disciplinary Action
CRIMINAL CONVICTIONS The Board of Registration is unable to obtain	n accurate data for this category at	the present time. This information will be
included when the court system is fully comp of complaint		
included when the court system is fully composed complaint MALPRACTICE		
included when the court system is fully composed complaint MALPRACTICE Details of claims paid for Dr. ANTHONY		No. of Years in Practice: #
included when the court system is fully composed complaint MALPRACTICE Details of claims paid for Dr. ANTHONY Date Amount Paid 0.0	0000 Basis for C	No. of Years in Practice: #
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Note: Please return the survey in the enclosed envelope to: Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111 1995-1997 Physician Registration Renewal Application

Registration No. Status	Fee Renewal Date Late Fee E \$250.00 10/11/95 \$25.00	
Mailing Address: GIOVANNINA M AN		Address (Mailing): City/Town: State: Country:
Directions: Before proceeding,	please read the instruction booklet. Some	questions are optional.
	manner will cause your license to lapse a the Commonwealth. (See enclosed letter	
· Add late fee if necessary.		
	i all attachments for your own records - 5. The Board will charge a fee for each cop- coupon at bottom of this page.	
Pre-Printed Information		Corrections of Pre-Printed Information
1. Other name(s), if any, under v	which you were licensed:	
2 Business Address	5:	Name: Address: City/Town: State: Country:
3. Date of Birth: Lic. Issue Date: 02/22/9	5ex: y 95 SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Lic. Issue Date (M/D/Y):/ / SS#:
Home Phone B	iusiness Phone) -	Home: () Business: () Full Name of Medical School:
4. Name of Medical School:		
Univ. of Souther of Medicine Year Graduated: 92	rn California School Degree: MD	Year Graduated: Degree (MD/DO):
	now licensed to practice (Abbr): つついん y were licensed to practice (Abbr): いいい	
6. Specialty Code(s) (See Table Code Hours per Weel		Code Hours per Week in Mass.
OBG 60-70		If OS, print specialty:
7. If you are currently American	Specialty Board certified, enter codes: (S	See Table 2)
Code:	Code:	
8. Drug license number(s), if an	y: a) Federal (DEA) b) Massachusetts	Federal (DEA): Mass:
9. Activity Status: I am applyi	ing to be registered with the following state	us: ACTIVE

· I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.

PRINT NAME AND NUMBER. Physician Last Name: APTITION Registration Number: 80184
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the
codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code: /(AP) Facility Code: /(AP)
1 , 0
Facility Code: 168 / (AP) Facility Code: / (AP) Facility Code: / (AP)
If 999, print name(s):
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3) Nove.
Facility Code: Facility
If 999, write name(s):
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, check one. List Insurer:
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: State how otherwise exempt: (ii) Otherwise exempt:
12. Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow? Yes V No (Check one)
13. a) What is your principal work setting? (See Table 4)
b) Care of patients in Massachusetts (See instruction booklet.)
i) How many hours per typical week are you currently involved in outpatient care in Mass? hrs/wk
ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care?
(See instructions for definition of primary care.)
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on
Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.
IN THE PAST TWO YEARS: YES NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your pro-
fessional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?
17. Have you been charged with any criminal offense, other than a minor traffic violation?
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or
have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?
25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested No, training program exemption (see instruction booklet).
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.
 Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.
• Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief,
I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies
even it you reside out-of-state or out of the United States.
 Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.
 I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.
Minimuma M Asstrony UA
Signature: Manual M. Atthour Ms Date: 10,3,95
~ <i>U</i>
<i>f</i>

BOARD OF REGISTRAT		Fee -\$350.00 to be submitted
Filed 7-3-9-3	For Office Use	Application FEB 3 1995
By:	2	0782 Date of Issue DIA GS/ABTION
Form of Fee: 330	Certificate #_8	Date of Issue The Date ON
Please Print	SWORN STATEMENT	Date: FEB 2, 1995
Name Alovanni NA MARIA Date of Birth	ANTHONY Address	
Place of Birth LOS ANGELES, CA		
Name on Birth Certificate Same. Pre-Medical Education	Phone #	Medical Education
School Univ of Southern Califo	School _	Univ of Southern California
Years Attended 1989 1982 198	4-1988 Years Alle	nded 1988 - 1992
Postgraduate Education & Medical School to the pre-	Hospital Appointment time.	ments from graduation <u>from</u>
Place	Position	Dates
Brigham & Womens Hosp/Mas	s General Hosp	Posidency- 1992 -> present OB/GyN
Is this your first full lother states where your a	icense? <u>√0S If ap</u> re or have been	plicable, please list all licensed:
Other names under which y	ou have been lic	ensed: None
List Specialty Boards by	which you are ce	rtified: <u>nonl</u>
REASON APPLYING FOR A MA Anticipated starting date Massachusetts: 7/1/95	if you have pos	i clinics outside BNH/MGH.
NOTE: Change of address Registration in Medicine of new address.	must be submitte in writing. Ple	d to the Board of ase include effective dates
included in this applicat statement made under pena	ion for licensum	
SIGNATURE OF APPLICANT		Date: <u>2/2/95</u>

COMMINIMENT OF THE BEDSHIP SEEDS (1) COMMINS OF PRINTER OF PRINTERS OF SECURIOR OF SECURIO	in the state of the second	
TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT. NAME: GIOVANNINA ANTHONY Day time phone #:	**************************************	
MAILING ADDRESS: Business Address:		
Address valid until: Ship 1996		
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.		
IMPORTANT NOTE: The Board's regulations, 243 CMR 8.02, define "disciplinary action" as referred to in the questions on this applica	tion. Please con	sult
this definition, which follows this portion of the application.	YES	NO
1. Has any medical maipractice claim been made against you in the last ten years (whether or not a lawsuit		
was filed in relation to the claim)? (You must complete Form 1B, attached, for <u>each</u> claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name?		
If eo, previous name:		-
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or		
improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
5. Have you ever falled any of the following exeminations: the FLEX examination, any state Board examination, falled Part III of the		
National Boards or falled to gain certification from the National Board of Medical Examiners?		
6. Have you ever falled a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Heve you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the		
last ten years by any governmental authority, by any hospital or health care facility, or by any professional		
medicel association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a Hoense to practice medicine or any healing art?		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason? 12. Have you ever, for any reason, lost American Specialty Board Certification?		-
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?		
 Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied. 		
restricted or eurrendered, or have you been called before or warned by this state or any other		
jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental liliness which has impaired your ability to practice medicine		
or to function as a student of medicine?		
17. Have you ever had an organic lilness which has impaired your ability to practice medicine or to function as a student of medicine? 18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions,		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		
"IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS."		
an annean con i ambania i leggo i on i dittieri sit aliministi libilotion (on 100 biolibit).		
NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated		
by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment		
pefore irreparable harm to the physician or patient occurs.		
P RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BO	ADD AWARE OF	TUC
NEW INFORMATION.	AND MAKE OF	I FIGS
certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c. 119 acc. 51A		
will read the Board's regulations, 245 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure	in Massachusetti	
hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.		
BIGNATURE: NAME DATE: 2/2/95		
~ U / ' '		



Commonwealth of Massachusetts Board of Registration in Medicine

FORM E

Ten West Street Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D. CHAIRMAN ALEXANDER F. FLEMING EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION
INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL
Please complete this form in full and return it <u>DIRECTLY TO THE</u> <u>ADDRESS ABOVE</u> . This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.
I CERTIFY THAT GIDVANNINA MARIA ANTHONY CREDITABLY
COMPLETED AT LEAST <u>TWO YEARS</u> OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:
UNIVERSITY OF SOUTHERN CALIFORNIA NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION
NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)
for admission to: UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICIN
LOS ANGELES, CALIFORNIA, USA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)
I FURTHER CERTIFY THAT GIOVANNINA MARIA ANTHONY NAME OF APPLICANT
HAS COMPLETED AND ATTENDED FOR ACADEMIC YEARS OF INSTRUCTION, NUMBER
OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR
AT: UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

FORM E CONTINUED ON NEXT PAGE



Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street Boston, Massachusetts 02111

(617) 727-3086

FORM E CONTINUED

DINESH PATEL, M.D. CHAIRMAN ALEXANDER F. FLEMING EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

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Year II	FROM:		21, 1989			ne 17, 1990		<u></u>
Vaara III &		MONTH	DAY	YEAR	MONTH	DAY	YEAR	
Years III & IV CONTINUUM		June D MONTH	18, 1990 DAY	YEAR	MONTH	DAY	YEAR	**-
48 wks year : 36 wks year :	III FROM:				o: May 29			_
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			NAME AND T	TILE (PL	EASE TYPE	OR PRINT)	LOS ANGELES	CA 90033
	SCHOO	L SEAL			DATE	: FEB 9	1995	-

NOTE: The date on the diploma is ealier than the actual dates of attendance. Commencement is governed by our main university, USC.

tification of Post-Graduate Training F

FORM G

Instructions: This form must be completed and signed by the Director of your dimernship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, ROBERT BARBIER!, M.D., CHAIRMAN, DEPT OF OB/GYN at Name TITLE BRIGHAM & WOMEN'S HOSP.
hereby certify that GIOVANNINA M. ANTHOM has served & 3 year(s)
of post-graduate training as a OB/GYN RESIDENT in OB/GYN Position Specialty
at BRIGHAM & WOMEN'S HOSPITAL, BOSTON . MA State
This program (is x is not approved by the ACGME or the RRC.
Dr. GIOVANNINA ANTHONY participated in this program from
JUNE , 1992 to PRESENT, and was issued was not Month Year Month Year
issued a certificate as proof of completion of said training. (If
not issued a certificate, please explain.)
SAID TRAINING TO BE COMPLETED JUNE 1996.
(NOT YET COMPLETED)
I further certify that at the time of completion of the above training,
this physician was, to the best of my knowledge, competent to practice
medicine and there was no disciplinary action outstanding or pending
involving him or her. Korsent Balba
Signature of Director
7-3-93
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Initial Limited License Application, Page 1 of 2

\$ 50.00 Fee Payable to The Commonwealth of Massachusetts

important:

. Read the accompanying instructions in their entirety before completing this form.

. Print legibly or type your answers.

. Answer all non-optional questions (front and back of form) completely—Even though the Board may have the information, it is not adequate to state that

the Board already has the information. Sign the application at the bottom of page two. Make a copy of this form and all attachments for your own records—you must give hospitals and other health care facilities copies for credentialing purposes.
Applicants please check one: i am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico X 2) Graduate of Foreign Medical School applying under the Special Refugee Physician Program
PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.
SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)
1. a) Name (LAST:) ANTHONY , (FIRST:) GIOVANNINA , (M.L.) M
1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name?
If yes, please specify (and attach documentation): NO.
1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: NO
2. a) Name & address of Massachusetts Training Hospital: Brigham & Women's Hosp. 75 Francis St. Boston MA 02115
2. b) Local residence address & telephone: 75 Francis St. Dept of Ob/Gyn Boston MA Tel. # (6/7)732-5445
3. Place of Birth: Los Angeles, cA
4. Date of Birth (MO/DA/YR): 5. Sex: MALEFEMALE/ 6. Social Security No. (Optional):
7. a). Name of Premedical school(e): Univ. Southern California 7 b)Location: Los Avigeles, CA
8. a) Medical School Name: Univ. of Southern California 8 b) Location: (City, State, Country) LOS Angeles, CA USA (See #3 under instructions)
8. c) Year Graduated: 1992 8. d) Degree: M.D. D.O. Other (Specify)
9. a) Previous post-graduate training:yes
b) Name of institution:
Address: N.A.
o) Name of Program: N.A. Dates of training: N.A.
Continue answer on additional page if necessary
10. If you have had any one of the following, please circle which one and attach an explanation to this form: a) Leave of absence from medical school
b) USMG more than four years of medical school education. c) FMG more than six years of medical education. Question 10 applies to meYes
X No. I have attached an explanation, Yes No.
SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.
This certifies that Govanning Anthony has been appointed to the position of intern, Resident,
Fellow in Program OB/GYN aiBnaham+ Women's Hospital beginning 6/20/92
Anticipated completion Date of training (Program)
This program is accredited by the ACGME: Yes No
If no, we have an ACGME approved training program in the applicant's speciality: YesNo
Designated Official's Signature: YMMU W. XLESUM
Type or Print Name and Title: Florence Stepian, Assistant Vice Tresident
(Applicant See reverse side - You must complete Section C) FORM 11/89
MW - 8/000 FFD. OK Batch # 366

massachusens dosto of Megistration in Medicine Limited License Application, Page 2 of 2
SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)
11. Other States where you are now licensed to practice (Abbreviate): hone
12. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate):
13, if more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes No No
14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes No If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes No Program Director's Certification has been requested: Yes No
Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.
15. has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
16. Have you been a defendant in any oriminal proceeding other than a minor traffic offense;
17. Are any formal disciplinary action (as defined by Board regulations; See Attached From 168) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been salled before or been warned by this state or any other jurisdiction including a federal agency?
19. Have you withdrawn an application for a medical license or been denied a medical ficense for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing are in fieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?
20. Have you had any mental lilness which has impaired your ability to practice medicine or to function as a student of medicine?
21. Have you had any organic lliness which has impaired your ability to practice medicine or to function as a student of Medicine?
22. Are you now, or have you been in the past, dependent upon alochol or drugs?
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 158)?
F RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.
I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec.51A
Pursuant to M.G.L. 0.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts
state tax returns and paid any Massachusatte state taxes that are required under law. Note: This applies even if you reside out-of-state or out of the country.
will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in
hereby 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 thousands.
Applicant's Signature: / Winking 11. Ptathong Date: 4 125 1 12



Commonwealth of Massachusetts Board of Registration in Medicine

FORM E

Ten West Street Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D. CHAIRMAN ALEXANDER F. FLEMING EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION
INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL
Please complete this form in full and return it <u>DIRECTLY TO THE ADDRESS ABOVE</u> . This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.
I CERTIFY THAT GIOVANNINA M. Anthony CREDITABLY NAME OF APPLICANT CREDITABLY
COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:
1/3/ LOS Argels, CA NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION
K \ 1 P-
NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)
for admission to: USC School of Medicine NAME OF MEDICAL SCHOOL
NAME OF MEDICAL SCHOOL
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)
CITY, STATE, COUNTRY)
I FURTHER CERTIFY THAT GIOVANNING Maria Anthony NAME OF APPLICANT
NAME OF APPLICANT
HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION, NUMBER
OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR
NAME OF MEDICAL SCHOOL OF MEDICINE
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

-STU. AFFAIRS-



SCHOOL SEAL

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street Boston, Massachusetts 02111

FORM E CONTINUED

			(61)	7) 727-308(6		
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An Agency within the Executive Office of Consumer Affairs and Business Regulation							
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FRANCES L. GREW, REGISTRAR USC SCHOOL OF VEDICINE 2025 ZONAL AVENUE, KAM 100-3 LOS ANGELES, CA 90033

DATE: UN

Commonwealth of Massachusetts, Board of Registration in Medicine



Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

Renewal

Fifty Dollar Fee Psyable to The Commonwealth of Massachusette

Board Use Only: Registration No.	Status Fee	Date				
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the Board alread	y has the information.	or our pourpolary + E	lau moifu ma bours			
Sign the application	at the bottom of page two. Is form and all attachment	s for your own records-	vou must give hossital	and other health gard	facilities copies for c	redentleling
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2. Mailing Address:	of Training Hospital: Bri	sham & hlamini	Hosa 75 F	miners Steel	SEN MA	
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	by Program Director:				(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	
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BECTION B. TO BE APPOINTMENT,	COMPLETED AND SIGNI	D BY THE DESIGNATED	OPPICIAL OF THE INS	TITUTION AT WHICH T	HEAPPLICANT HAB	RECEIVED AN
This certifies that	BIOVANNINA	Anthony	has been appointed to	the position of Intern	Resident	
Fellow In Progr	mOB/GYN	4	Indian Dome	us la b	Min 7/1/93	and
Antiolpated complete	(PTOGRA	m6/30/96	((institution)			
This program is acc	predited by the ACGME: Y	ee No	's specialty: Yes N			
: 1955년 전 1953년 - 1953년 - 1953년 - 195	$\mathcal{L}D$	213				
Designated Official	s Signature: T)QUO	y XXVIII				
Type or Print Name	and Title: Kanch	L. Whote	Date 3//	6/99		
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FORM 1/91		(Applicant See reverse a	ide - You must complete	Bection O)		
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SECTION O: Sworn State	ment to be Completed	oy Applicant (Complete Reverse	Side Aleo)		
7. Other States where you (Abbreviate):	are now fully koensed to	practice:			
Quastions 8 through 14 m	tot applicable.				
and the second of the first terms of the second		(not N/A) to <u>each</u> question. Provi	de deteils on Form IBE	, attached	Yee
15. Has any medical malt	oractice cisim been mac	le against you (whether or not a	lawauit was filed in i	eletion to the claim)?	
		roceeding other than a minor tr			
17. Are any formal disolo taken against you by (international, nation	linary charges pending any governmental auth	or has disciplinary sotion (as d ority, hospital or plinar health or	efined by Board regul tre facility, or profess	latione: Ben Attaches f lonal medical associat	rom 168) been on
18. Has your privilege to surrendered, or have	possess, dispense of p you been called before	resoribe controlled substances or been warned by this state or	been suspended, ray any other jurisdiction	oked dended restiles i notualité a secratico	d ency?
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20. Have you had any me	ntal iliness which has l	mpaired your ability to practice	mediaine or to funcil	on as a student of med	dine?
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23. Have you ever been d during an examination Form (58) at an acad	lenied the privilege of to n or otherwise been sul emic institution, since y	iking or finishing an examinatio spect to any disciplingry action (our matriculation in college?	n or been accused or as defined by Board	egulations (300 Atlact	
24. Heve you ever had str suspended or revoke regulations; See Atte	aff privileges, employm d, or have you resigned shed Form 168)?	ent or appointment in a hospital from a medical staff in lieu of d	or other health dere legiplinary sollon (se	Inatitution it enled, defined by Doord	
F RESPONSES TO QUE AWARE OF THE NEW IN	STIONS 15-24 CHANGE FORMATION.	DURING THE TIME THE APPLIC	CATION IB PENDING,	THE APPLICANT NUB	MAKE THE BOARD
Pursuant to M.G.L. c.620 tax returns and paid any country.	eec.49A, I certify under Maceachusette state ta	the penaltics of perjury that to kee that are required under law.	my best knowledge Note: This applies	and belief, littere filled won it you realds out-o	my Macanthucetts state (setate or out of the
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Applicant's Signature:	furanama.	M Fathory			<u>ن ایالی</u>
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Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

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. Read the accompanying instructions in their entirety bet	fore completing this form				
 Print legibly or type your enswers. Answer all non-optional questions (front and back of for 	m) completely. Even the	such the Board may have th	e information. I	le not adequ	ate to state that
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Sign the application at the bottom of page two. Nake a copy of this form and all attachments for you	ir ann receide-uair m	riet also beenftels and other	وما ومدة والمعدر	مملحه مملاه	tor occupation
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SECTION A: Swom Statement to be Completed by Ap	piloent. (Complete Rev	orse Side Also)			
1. Name (LAST:) ANTHONY	(FIRST:)	GIOVANNINA	M)	M.	
2. Meiling Address:					
3. Name & Address of Training Hospital: <u>Brigham</u>	E Women's Hood Ho	d 75 Francis St.	BOSTON N	62115	
4. Medical School Name: MINIVESTY of Sens	them Californi	a .			
5. Current Limited License Number: 92-1796	2.96 V				
8. To be completed by Program Director:	en e				
hearing and the that the above named abundance to be	and stardingly the B	مراوع المستقل ا			وتم فعمل مه شمولی
hereby gertify that the above-named physician is in pending disciplinary action in this program?	A No				Man m han a
Type or Print Name and Title Robert 1. Barbi	AND DE	ector. Residency T	rainino Pr	oanem	
Kosert); 6/				
Signature of Program Director	SAMUL.	531-94		a.	
RECTION B: TO BE COMPLETED AND SIGNED BY THAPPOINTMENT.	HE DESIGNATED OFFI	DIAL OF THE MISTITUTION	AT WHICH THE	APPLICANT I	HAS RECEIVED AN
This certifies that GIOVANNINA AN	JTHONY mas	been appointed to the positio	n of Irakon	Resident	
or 1641				//_	ba
ellowin Program00 G//		SWH WHILLIAM)	bagirni	1970/	Zend
this program is accredited by the ACCAIS: Yes it is no, we have an ACCAISE approved training profitm	o in the applicant's spec	ialty: Yes No			
	// //				
Designated Official Signature: A SCI	10 Theffer son			-	
Type or Print Name and Title: 5 HALLN HE	FFERNAN	Des 6/8 /5/			
GME PROGRA	M COORDIN	Arol	/	BULL	
	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ou must complete Section (1)	A V	11	
ORM 1/91			信息 为1		
			人為基準量		

	propropries	REGELVEN
ECTION C: Sworn Statement to be Completed by Applica	II (COUDING GAARDS DIG WAY)	
7. Other States where you are now fully licensed to practice: (Abbreviate):		JUNE 3 1994
Questions & through 14 not applicable.		PEYSICIAN SERVICES
Questions 15 through 24. Check either YES or NO (not N/A) to	each question. Provide details on Form 188, and	Y
18. Has any medical majorantice claim been made against	you (whether or not a laweuit was filed in relat	· · · · · · · · · · · · · · · · · · ·
16. Have you been a defendant in any oriminal proceeding		
17. Are any formal disciplinary charges pending or has dis- taken against you by any governmental authority, hosp (international, national, state or loosi)?	olphinally setten (es defined by Rostyl regulational et either health care landity, or protessions	(i) the Attacking (from 16\$) been the line and station
16. Has your privilege to possess, dispense or prescribe of surrendered, or have you been called before or been wi	ontrolled substances been suspended, revoked arned by this state or any other jurisdiction ind	Maria in the state of the state
19. Have you withdrawn an application for a medical licens voluntarily surrendered a license to practice medicine of by Board regulations; see attached Form 188)?	e or bash denied a medical libered by any res or any besing art in help of designingly selion (
20. Have you had any mental liliness which has impaired yo	- 「『『記念』、「、 ・・・・・・・・ おります。 記録(たっきん) 生産発剤・「ごだった!	470 362 45 364 46 46 46 46
21. Have you had any organic lilness which has impaired y	그 중에요살하는 그는 하는 날이다. 그는 사용을 모음한	a & student of medicine?
22. Are you now, or have you been in the past, dependent u		disc and as it proper conduct
 Have you ever been denied the privilege of taking or find during an examination or otherwise been extens to any Form (68) at an academic institution, since your matrice 	deaplinary solion (as defined by licerd regulation in sollege?	
14. Have you ever had staff privileges, employment or apposuspended or revoked, or have you realigned from a meregulations; See Attached Form 15B)?	intrigent in a hospital or other health ours inet does staff in lieu of deciplinary udition (or cell	
P RESPONSES TO QUESTIONS 15-24 CHANGE DURING THANKE OF THE NEW INFORMATION.	HE TIME THE APPLICATION IN PERIONAL THE	APPLICANT NUET MAKE THE BOARD
Pursuant to M.G.L. 0.42C sec.40A, I certify under the penalt ax returns and paid any Massachusette state taxes that are	les of perjury that, to my best knowledge and	selidi. Limya diad any Massochusella al
lax returns and peld any Massachusetts state taxes that are	regulated under law, Notice This applice aven	New reside an of the or out of the
cortify that I will fulfill my obligation to report abuse or neg		
will read the Board's regulations, 243 CMR 1.00 through 3. Hessenhusetts.		
hereby certify under the penalties of perjury that all inform	ation an this form-front and book and ALL	theelied pegage is true to the best of my
	mu	3,29,94
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