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

10/60

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. The Board will charge a fee for each copy.
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

OCT 21 1997

Registration No.: 80782 Renewal Date: 10/11/97

REDACTED COPY

OCT 9 1997

1. Activity Status: (Check only one)
   - [X] Active
   - [ ] Inactive *(see below)
   - [ ] Retiring (see instructions)
   - [ ] Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
GIOVANNINA M ANTHONY, M.D.

B) Home Address:

Home Phone:
Business Phone: ( ) -

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 02/22/95 D) SS#:

5. A) Name of Medical School:
Univ. of Southern California School of Medicine
B) Year Graduated: 92 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	70	Obstetrics and Gynecology

Corrections (type or print)

Other Name(s): _____

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Other Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Home:
Business: (_____) _____

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): _____
Lic. Issue Date (M/D/Y): ___/___/___ SS#: _____

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree (MD/DO): _____

Code(s)	Hours Per Week in Mass.
___ ___ ___	Currently: 0 (work on locum tenens basis)
___ ___ ___	

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:
A) Federal (DEA):
B) Massachusetts:

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Abbr: CA OR MI PA

Abbr: ___ ___ ___ ___

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

Giovannina Anthony, MD 9/30/97

PRINT NAME AND NUMBER: Last Name: ANTHONY Registration Number: 80782

10. A. Current health care facilities 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 health care facilities where you have admitting privileges (AP).

Facility Code: 998/__(AP) Facility Code:___/__(AP) Facility Code:___/__(AP)
Facility Code:___/__(AP) Facility Code:___/__(AP) Facility Code:___/__(AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

Facility Code: 921 Facility Code: 168 Facility Code: __ Facility Code:___ Facility Code:___
If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ____b) Letter of Credit
Name of Insurer: American Continental Insurance Co.

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a)_____ Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 9 9 (variable: locum tenens)

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care _____hrs/wk b) inpatient care _____hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? _____%

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **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?		
15. **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?		
16. 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?		
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, 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?		
22. 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

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature Marianne Anthony Date: 9 / 30 / 97

I. PHYSICIAN INFORMATION

GIOVANNINA	M	ANTHONY	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 80782
License Status Active

First Issue Date 02/22/95

1A Garden Ct.
#3
Boston, MA 02113-2034
U.S.A.

Hospital Affiliation

Brigham & Women's Hospital
Massachusetts General Hospital
Clinic

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☐ Yes ☐ No

Accept Medicaid? ☐ Yes ☐ No

II. EDUCATION & TRAINING

Univ. of Southern California School of Medicine	MD	92
Medical School	*Degree*	*Date*

Make corrections here

Brigham & Women's Hospital / Massachusetts General Hospital	6/92 - 6/96
Residency Program(s)	*Start* *End*
Residency Program(s)	*Start* *End*
Residency Program(s)	*Start*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name:

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint .....

.....

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. ANTHONY

Date	Amount Paid 0.0000	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

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
80782	ACTIVE	$250.00	10/11/95	$25.00

Mailing Address:

GIOVANNINA M ANTHONY, M.D.

Correction of Mailing Address

Address (Mailing): _____

_____

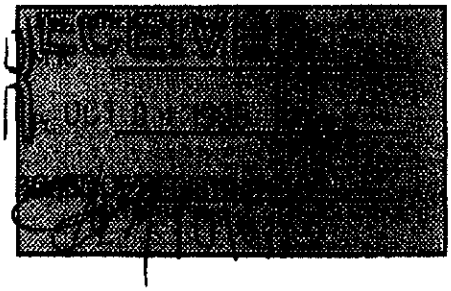
City/Town: _____

State: _____

Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- **Add late fee if necessary.**
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.



Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. Business Address:

3. Date of Birth: Sex: F
   Lic. Issue Date: 02/22/95 SS#:

   Home Phone Business Phone
   ( ) -

4. Name of Medical School:
   Univ. of Southern California School of Medicine
   Year Graduated: 92 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): none
   b) States where you previously were licensed to practice (Abbr): none

6. Specialty Code(s) (See Table 1):

Code	Hours per Week in Mass.
OBG	60-70

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: Code: ϕ

8. Drug license number(s), if any:
   a) Federal (DEA)
   b) Massachusetts

Corrections of Pre-Printed Information

Name: _____

Address: _____

City/Town: _____

State: _____ Zip: _____

Country: _____

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____

Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____

_____

Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____

Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

- **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: ANTHONY Registration Number: 80986

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: 921 / ___ (AP) Facility Code: 996 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

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) none

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

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: ProMutual (previously Joint Underwriters Ass)

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: _____ (ii) Otherwise exempt: _____

State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ✓ No ___ (Check one)

13. a) What is your principal work setting? (See Table 4) 10

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? 6 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 0 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 20 %

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 professional 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 if 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.**

Signature: Marianna M. Anthony MD Date: 10/3/95

THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

$ 350.00

Fee -~~$300.00~~ to be submitted

RECEIVED FEB 3 1995 BOARD OF REGISTRATION IN MEDICINE

Filed: 2-3-95

By: MLV

Form of Fee: 350

For Office Use

Application # _____

Certificate # 80782 Date of Issue 2/22/95

Please Print

SWORN STATEMENT

Date: FEB 2, 1995

Name GIOVANNINA (First) MARIA (Middle) ANTHONY (Last)

Address _____

Date of Birth _____

Place of Birth LOS ANGELES, CA

Name on Birth Certificate same

Phone # _____

Pre-Medical Education

School Univ of Southern California

Years Attended ~~1980~~ error 1988 – 1992 1984 – 1988

Medical Education

School Univ of Southern California

Years Attended ~~1988~~ error 1988 – 1992

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Brigham & Womens Hosp/Mass General Hosp	Residency- OB/GyN	1992 → present

Is this your first full license? Yes If applicable, please list all other states where your are or have been licensed:

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: none

REASON APPLYING FOR A MA LICENSE to work in clinics outside BWH/MGH

Anticipated starting date if you have position pending in Massachusetts: 7/1/95

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

AFFIDAVIT OF APPLICANT:

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

Giovannina M Anthony

SIGNATURE OF APPLICANT

Date: 2/2/95

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: GIOVANNINA ANTHONY Day time phone #: _____

MAILING ADDRESS: _____ Business Address:

_____ _____

Address valid until: July 1996

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. Has any medical malpractice 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 each 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 so, 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 failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have 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 medical association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a license 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)? _____ _____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, 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 illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness 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.

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 before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS 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.
I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: Giovannina Anthony DATE: 2/2/95

Commonwealth of Massachusetts
Board of Registration in Medicine
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

FORM E

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 DIRECTLY TO THE ADDRESS ABOVE. 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 MARIA ANTHONY (NAME OF APPLICANT) CREDITABLY

COMPLETED AT LEAST TWO YEARS 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 MEDICINE
NAME OF MEDICAL SCHOOL

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 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE
NAME OF MEDICAL SCHOOL

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

NAME OF APPLICANT GIOVANNINA MARIA ANTHONY

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

		MONTH	DAY	YEAR		MONTH	DAY	YEAR
Year I	FROM:	August	29,	1988	TO:	June	16,	1989
Year II	FROM:	August	21,	1989	TO:	June	17,	1990
Years III & IV CONTINUUM	FROM:	June	18,	1990	TO:			
48 wks year III 36 wks year IV 84 weeks total	FROM:				TO:	May	29,	1992
	FROM:				TO:			
	FROM:				TO:			
	FROM:				TO:			

AND HAS RECEIVED/~~WILL RECEIVE~~ A DEGREEE OF Doctor of Medicine

ON May 8, 19 92.

-STU.AFFAIRS-

Frances L. Grew
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

9 FEB 95 7:57

FRANCES L. GREW, REGISTRAR
USC SCHOOL OF MEDICINE
1975 ~~2025~~ ZONAL AVENUE, KAM 100-B
LOS ANGELES, CA 90033

NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL 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.

Certification of Post-Graduate Training

FORM G

FEB 1995

Instructions: This form must be completed and signed by the Director of your internship 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 BARBIERI, M.D. (Name), CHAIRMAN, DEPT OF OB/GYN at BRIGHAM & WOMEN'S HOSP. (Title)

hereby certify that GIOVANNINA M. ANTHONY has served ≈ 3 year(s)

of post-graduate training as a OB/GYN RESIDENT (Position) in OB/GYN (Specialty)

at BRIGHAM & WOMEN'S HOSPITAL (Hospital), BOSTON (City), MA (State).

This program (is) X is not _____ approved by the ACGME or the RRC.

Dr. GIOVANNINA ANTHONY participated in this program from

JUNE (Month), 1992 (Year) to PRESENT, (Month), _____ (Year) and was issued _____ was not

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.

Robert Barbieri
Signature of Director

2-3-95
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

92-796 OK

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 ___ 3) 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.I.:) 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.# (617) 732-5445

3. Place of Birth: Los Angeles, CA

4. Date of Birth (MO/DA/YR): 5. Sex: MALE ___ FEMALE ✓ 6. Social Security No. (*Optional*): ___ ___ ___

7. a). Name of Premedical school(s): Univ. Southern California (City, State, Country) 7 b) Location: Los Angeles, CA

8. a) Medical School Name: Univ. of Southern California (See #3 under Instructions) 8 b) Location: (City,State,Country) Los Angeles, CA USA

8. c) Year Graduated: 1992 8. d) Degree: M.D. ✓ D.O. ___ Other (Specify) ___

9. a) Previous post-graduate training: ___ yes ✓ no

b) Name of Institution: ___

Address: N.A.

c) 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 me ___ Yes 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 Giovannina Anthony has been appointed to the position of Intern ___, Resident ✓, Fellow ___ in Program OB/GYN (Program) at Brigham + Women's Hospital (Institution) beginning 6/20/92

Anticipated completion Date of training 6/96.

This program is accredited by the ACGME: Yes ✓ No ___

If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

Designated Official's Signature: Florence W. Stepian

Type or Print Name and Title: Florence Stepian, Assistant Vice President

(Applicant See reverse side - You must complete Section C)

FORM 1 1/89

RECEIVED MAY - 8 1992 BOARD OF REGISTRATION IN MEDICINE COMMONWEALTH OF MASSACHUSETTS

FED. OK Date 5/12

Batch #. 366 By VM

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now licensed to practice
(Abbreviate): none

12. States where you previously were licensed to practice (This includes Residency Training Licenses)
(Abbreviate): none

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 X I have attached an explanation: Yes___ No___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No X 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.

	Yes	No
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 criminal proceeding other than a minor traffic offense:		
17. Are any formal disciplinary action (as defined by Board regulations; See Attached From 15B) 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 called 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 license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing are in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness 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 alcohol 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 15B)?		

IF 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. c.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 Massachusetts state taxes that are required under law. Note: This applies even if you reside out-of-state or out of the country.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I 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 knowledge.

Applicant's Signature: Giovannina M. Anthony Date: 4/25/92

[redacted]

Commonwealth of Massachusetts
Board of Registration in Medicine
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

FORM E

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 DIRECTLY TO THE ADDRESS ABOVE. 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

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

USC, Los Angeles, CA
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

N/A
NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: USC School of Medicine
NAME OF MEDICAL SCHOOL

Los Angeles, CA, USA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT Giovannina Maria Anthony
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

AT: Univ of Southern California School of Medicine
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

-STU.AFFAIRS-

29 APR 92 2:03

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

FORM E CONTINUED

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

NAME OF APPLICANT Giovannina Maria ANTHONY

MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

1st FROM: 8 (MONTH) 29 (DAY) 1988 (YEAR) TO: 6 (MONTH) 16 (DAY) 1989 (YEAR)

2nd FROM: 8 (MONTH) 21 (DAY) 1989 (YEAR) TO: 6 (MONTH) 17 (DAY) 1990 (YEAR)

3/4 Continuum FROM: 6 (MONTH) 18 (DAY) 1990 (YEAR) TO: 5 (MONTH) 29 (DAY) 92 (YEAR)

~~FROM:~~ _____ (MONTH) _____ (DAY) _____ (YEAR) TO: _____ (MONTH) _____ (DAY) _____ (YEAR)

FROM: _____ (MONTH) _____ (DAY) _____ (YEAR) TO: _____ (MONTH) _____ (DAY) _____ (YEAR)

FROM: _____ (MONTH) _____ (DAY) _____ (YEAR) TO: _____ (MONTH) _____ (DAY) _____ (YEAR)

FROM: _____ (MONTH) _____ (DAY) _____ (YEAR) TO: _____ (MONTH) _____ (DAY) _____ (YEAR)

AND HAS RECEIVED/~~WILL RECEIVE A~~ DEGREEE OF Doctor of Medicine

ON MAY 8 19 92.

Frances L. Grew
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE: JUN 4 1992

FRANCES L. GREW, REGISTRAR
USC SCHOOL OF MEDICINE
2025 ZONAL AVENUE, KAM 100-3
LOS ANGELES, CA 90033

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 Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

M.R. ____ / ____ / ____
Pr. ____ / ____ / ____
Bic JKW 3 / 19 / 93
Cn ____ / ____ / ____
D/R ____ / ____ / ____
R. ____ / ____ / ____

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.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) ANTHONY (FIRST:) GIOVANNINA (M.I.) M
2. Mailing Address: ____
3. Name & Address of Training Hospital: Brigham & Women's Hosp. 75 Francis St. Boston MA
4. Medical School Name: University of Southern California
5. Current Limited License Number: 92-7967-96
6. To be completed by Program Director:

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes X No

Type or Print Name and Title Kenneth J. Ryan MD

Signature of Program Director Kenneth J. Ryan MD

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 Giovannina Anthony has been appointed to the position of Intern ____ Resident ✓ ____ Fellow ____ in Program OB/GYN (Program) at Brigham + Women's (Institution) beginning 7/1/93 and Anticipated completion date of training 6/30/96

This program is accredited by the ACGME: Yes ✓ No ____
If no, we have an ACGME approved training program in the applicant's specialty: Yes ____ No ____

Designated Official's Signature: Randi L White

Type or Print Name and Title: Randy L. White Date 3/16/93
Graduate Medical Education Program Administrator

(Applicant See reverse side - You must complete Section C)

FORM 1/91

RECEIVED
MAR 22 93
BOARD OF REGISTRATION IN MEDICINE

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): none

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
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 criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached Form 15B) 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 called 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 license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness 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 alcohol 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 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

Pursuant to M.G.L. c.62O 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 Massachusetts state taxes that are required under law. Note: This applies even if you reside out-of-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I 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 knowledge.

Applicant's Signature: Giovannina M Anthony Date: 3/10/93

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

RECEIVED
JUN 3 1994
PHYSICIAN SERVICES

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

M.R.	JKW	6/6/94
Pi.		/ /
Bi.		/ /
Ch.		/ /
D.E.		/ /
Fi.		/ /

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.*
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SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

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2. Mailing Address:
3. Name & Address of Training Hospital: Brigham & Women's Hospital 75 Francis St. Boston MA 02115
4. Medical School Name: University of Southern California
5. Current Limited License Number: 92-7967-96
6. To be completed by Program Director:

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes X No

Type or Print Name and Title Robert J. Barbieri, M.D., Director, Residency Training Program

Signature of Program Director Robert J. Barbieri 5-31-94

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 GIOVANNINA ANTHONY has been appointed to the position of Intern ____, Resident ✓

Fellow ____ in Program OB/GYN (Program) at BWH (Institution) beginning 6/20/94 and

Anticipated completion date of training 6/20/96

This program is accredited by the ACGME: Yes ✓ No

If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___

Designated Official's Signature: Shawn Heffernan

Type or Print Name and Title: SHAWN HEFFERNAN Date 5/31/94

GME PROGRAM COORDINATOR

(Applicant See reverse side - You must complete Section C)

1994

FORM 1/91

RECEIVED
JUN 3 1994
PHYSICIAN SERVICES

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate):_____

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
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16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
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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 15B)?		

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Pursuant to M.G.L. c.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 Massachusetts state taxes that are required under law. (Note: This applies even if you reside out-of-state or out of the country.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I 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 knowledge.

Applicant's Signature: Gianmarina Anthony Date: 3/29/94