OPR/LMD-040 (2/96)

BOARD USE ONLY

License Number

Date of Licensure 10/2/96

Michigan Department of Commerce
**Board of Medicine**
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

LIC. & REG. AMT. RECD. $ 225.00

SEP 12 1996

# APPLICATION FOR MEDICAL AND CONTROLLED SUBSTANCE LICENSES

*Authority: Public Act 368 of 1978, as amended*
*If this form is not completed, a license will not be issued.*

**I AM APPLYING FOR THE FOLLOWING:**
- ☐ License by Examination Fee: $140.00
- ☒ License by Endorsement (Must Currently be Licensed in Another State) Fee: $140.00
- ☒ Controlled Substance License Fee: $85.00

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| | | |
|---|---|---|
| | Daytime Phone Number (412) [redacted] | Previous License Number Massachusetts #80782 |
| Name (Last, First, Middle) ANTHONY, Giovannina Maria | Previous Name Used (if applicable) none | |
| Date of Birth [redacted] 1966 | Issue Date (Board Use Only) 10-3-96 | |
| Street Address [redacted] | | Zip Code 15232 |
| City Pittsburgh | State PA | Social Security Number [redacted] |

**Check the appropriate answer to each of the following questions. Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony? ☐ YES ☒ NO
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? ☐ YES ☒ NO
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? ☐ YES ☒ NO
4. Have you been treated for substance abuse in the past 2 years? ☐ YES ☒ NO
5. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ YES ☒ NO
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ YES ☒ NO
7. Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ YES ☒ NO
8. Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☒ NO
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ YES ☒ NO
10. Do you hold or have you ever held a medical license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☒ YES ☐ NO

| State | License Number | Date of Issue | Basis for Licensure |
|---|---|---|---|
| Massachusetts | # 80782 | June 1995 | |
| | | | |
| | | | |

**Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.**

| Name and address of Institution | Dates of Attendance From | To | Degree |
|---|---|---|---|
| University of Southern California Los Angeles, CA 90033 | 9/84 | 5/88 | Bachelor of Science: Biomedical Engineering |
| | | | |
| University of Southern California Los Angeles, CA 90033 | 9/88 | 6/92 | M. D. |
| Brigham & Women's Hospital/ Mass General Hosp. Boston, MA | 6/92 | 6/96 | Residency: Obstetrics and Gynecology |

**Provide a description of your professional medical experience. Attach additional sheets if necessary.**

| Name and address of Employer | Dates of Practice From | To | Duties |
|---|---|---|---|
| Women's Health Services Chestnut Hill, MASS | 6/95 | 6/96 | Staff Gynecologist |
| Repro Associates Boston, MA | 6/95 | 6/96 | Staff Gynecologist. |
| | | | |
| | | | |
| | | | |

## CONTROLLED SUBSTANCE LICENSE APPLICATION

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

**Applicant's Signature** Giovannina M. Anthony MD **Date** 9/5/96

## SIGNATURE AND AFFIDAVIT

I understand that it is the policy of this agency to secure conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

This affidavit **MUST** be signed in the presence of a Notary Public. Failure to do so will void this application.

**Signature of Applicant** Giovannina M Anthony MD **Date** Sept 6, 1996

Subscribed and sworn to before me this 6 day of SEPTEMBER, 19 96.

Jennifer D. Patterson
Notary Public

My Commission Expires: May 9, 1998

County/State: Delaware PA

# NATIONAL BOARD OF MEDICAL EXAMINERS®

## ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

**Diplomate Name:** Giovannina Maria Anthony, MD

**Date of Birth:** [redacted]/1966

**Certification Date:** 07/01/1993 **Certificate #:** 421544

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

| Exam | Test Date | Total Test | Min. Pass | Pass/ Fail | Anat | Phys | Bioc | Path | Micr | Phar | Beh Sci |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NBME PART I | Jun 1990 | [redacted] | | PASS | [redacted] | | | | | | |

| Exam | Test Date | Total Test | Min. Pass | Pass/ Fail | Med | Surg | Ob/Gyn | PM/PH | Ped | Psych |
|---|---|---|---|---|---|---|---|---|---|---|
| NBME PART II | Apr 1992 | [redacted] | | PASS | | | | | | |
| NBME PART III | Mar 1993 | [redacted] | | PASS | | | | | | |

**DATE:** 09/20/1996

**SEE OTHER SIDE FOR SCORE INFORMATION**



MI1060

OPR/LMD-200 (11/95)

Michigan Department of Commerce
**Board of Medicine**
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

# CERTIFICATION OF POSTGRADUATE TRAINING

*Authority: Public Act 368 of 1978, as amended*
*If this form is not completed, a license will not be issued.*

**Instructions**: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

## SECTION I - APPLICANT INFORMATION

| | |
|---|---|
| Applicant's Name (Last, First, Middle)<br>ANTHONY, Giovannina Marie | |
| Street Address<br>[redacted] | |
| City<br>pittsburgh | |
| State<br>Pennsylvania | ZIP Code<br>15232 |
| Social Security Number<br>[redacted] | Date of Birth<br>[redacted]66 |

| | |
|---|---|
| Signature of Applicant<br>Giovannina M. Anthony MD | Date<br>Sept 5, 1996 |

**Applicant: Upon completion of Section I, send this form to the director of your medical education for completion of Section II on the reverse side of this form.**

## THIS SIDE TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on the reverse side of this form.

## SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

BRIGHAM & WOMEN'S HOSPITAL

Street Address of Hospital

75 FRANCIS STREET
BOSTON, MA 02115
(617) 732-6444

City, State and ZIP Code

I certify that ANTHONY, GIOVANNINA (Applicant's Name) a graduate of the

UNIVERSITY OF SOUTHERN CA medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 6/20, 19 92, to 6/30, 19 96, in the clinical area of OB/GYN.

Is this training program accredited by ACGME or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☒ Yes ☐ No

Shawn N. Vanner
Signature of Director of Medical Education

9/18/96
Date of Signature

Shawn Vanner
Graduate Medical Education
Program Administrator
Print or Type Name of Director of Medical Education

SEAL

If hospital has no seal, please indicate.

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

OPR/LMD-091 (8/95)

Michigan Department of Commerce
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

# CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

*Authority: Public Act 368 of 1978, as amended*
*If this form is not completed, a license will not be issued.*

**Instructions**: Applicant complete Section I. Type or print your name exactly as it appears on your application. **Send this form to be completed and mailed directly to the board by the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.**

## SECTION I - APPLICANT INFORMATION

| | |
|---|---|
| **Applicant's Name (Last, First, Middle)**<br>ANTHONY, Giovannina Marie | |
| **Street Address**<br>[redacted] | |
| **City**<br>Pittsburgh | |
| **State**<br>Pennsylvania | **ZIP Code**<br>15232 |
| **Social Security Number**<br>[redacted] | **Date of Birth**<br>[redacted]66 |
| **Date of Admission**<br>September 1988 | **Date of Graduation**<br>5/8/92 |

| | |
|---|---|
| **Signature of Applicant**<br>Giovannina M. Anthony MD | **Date**<br>Sept 5, 1996 |

**Applicant: Upon completion of Section I, send this form to the dean of your medical school for completion of Section II on the reverse side of this form.**

**THIS SIDE TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL**

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on the reverse side of this form.

## SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

University of Southern California School of Medicine

Street Address of Medical School

1975 Zonal Avenue

City, State and ZIP Code

Los Angeles, CA 90033

I certify that Giovannina Marie Anthony, M.D. (Applicant's Name) attended the medical school named above from August 29, 19 88, to May 29, 19 92, and was granted the degree of Doctor of Medicine

-STU AFFAIRS

on M.D. Dated: May 8, 19 92.

12 SEP 96 10:

P Katsufrakis — Signature of Dean or Registrar

September 16, 1996 — Date of Signature

Peter J. Katsufrakis, M.D.
Associate Dean, Student Affairs
U.S.C. School of Medicine
1975 Zonal Avenue - KAM 100E
Los Angeles, CA 90033

Print or Type Name of Dean or Registrar

SEAL

If school has no seal, please indicate.

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
(617) 727-3086
Fax: (617) 451-9568
An Agency within the Executive Office of Consumer Affairs and Business Regulation



September 13, 1996

To Whom It May Concern:

This is to certify that GIOVANNINA M ANTHONY, a graduate of UNIV. OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE in the year 1992, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 80782 was issued to Dr. GIOVANNINA M ANTHONY on 02/22/95. THIS LICENSE IS CURRENT. The expiration date is 10/11/97. Our files contain NO OPEN or CLOSED complaints, and NO formal disciplinary action regarding this physician.

SEAL

Nishan J. Kechejian, M.D.,
Secretary

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from Courts, Insurers, Hospitals, etc.).