RHODE ISLAND
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

FULL LICENSE VERIFICATION

****

PHYSICIAN:	MARI J. BENTLEY, MD
DATE OF BIRTH:	09/02/1966
LICENSE NUMBER:	MD10568
DATE ISSUED:	04/27/2001
LICENSE STATUS:	Inactive
EXPIRATION DATE:	06/30/2002
MEDICAL SCHOOL:	University of Massachusetts Medical School
GRADUATION YEAR:	1998
EXAM:	USMLE - USMLE III

This license information was last updated on: 11/20/2016

****

This is to certify that the above-named physician is licensed to practice medicine in the State of Rhode Island. There have been no disciplinary actions taken against this physician's license.

Lauren Lasso
Medical License Coordinator
Board of Medical Licensure & Discipline

November 21, 2016

COMMONWEALTH of VIRGINIA

VERIFICATION

Re: **Mari Bentley**
127 Fuller Street #1
Brookline, MA02446

From: Alan Heaberlin
Deputy Director, Licensure
Virginia Board of Medicine

Subj: Licensure Verification

Date: November 21, 2016

Profession:	**Medicine & Surgery**
License Number:	**0101261335**
Issued On:	**10/13/2016**
Expires:	**09/30/2018 ***

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained by our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

* The expiration date of 1956 indicates that there is no recorded date of expiration for this license, and that it expired sometime prior to 1980.

NOTE: The Board of Medicine no longer provides a raised seal on this document.

Initial Medical Licensure
PERSONAL INFORMATION
12/2015 INT

STOP! Completed application and check must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

APPLICATION FOR INITIAL MEDICAL LICENSURE

FOR BANK USE ONLY
Date _____
Check Number _____ _____
Amt Paid ____
Name Code _____
AppID 17

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): Bentley

First name and middle name: MARI

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

MARY JOSEPHINE MANSFIELD

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**

7648 Belair Road

City: Baltimore State: MD Zip Code: 21236-

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code

4. **Telephone (s):** Home Office:

Cell/Pager: E-mail address:

5. **Date of Birth:** Month Day Year

6. **Gender:**

7. **Race:** Multiracial applicants may select all applicable categories

Ethnicity:

CUSTOMER SERVICE
RECEIVED
NOV 07 2016

8. **Social Security Number:**

For Board Use Only

License Number: D8263252 BPQA School Code: 624016
Date Issued: 11/29/16 Federation School Code:
Licensed By: _____ Licensing Exam: USMLE

BOARD OF PHYSICIANS

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	06	98

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity:	Address:
06	98	TO	06	01	Family Medicine Internship and Residency Memorial Hospital of Rhode Island/Brown University	111 Brewster Street Pawtucket, RI 02860
07	01	TO	01	02	maternity leave of absence	
01	02	TO	07	09	Physician, Dept of Family Medicine Boston Medical Center/Boston U. School of Medicine	1 BMC Place Boston, MA 02118
07	09	TO	present		Physician, Dept of Family Medicine East Boston Neighborhood Health Center	10 Gove St E. Boston, MA 02128
07	09	TO	present		Per diem Physician Four Women Health Services	150 Emory St Attleboro, MA 02703
07	13	TO	present		Part-time Physician Boston Medical Center/Boston U. School of Medicine	1 BMC Place Boston, MA 02118
		TO				
		TO				

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Print Your Name: MARI BENTLEY, MD, MPH Date: 10/30/16

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
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month	year	TO	month	year	Activity:
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month	year	TO	month	year	Activity:
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month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:

10. MEDICAL EDUCATION: List all medical schools you have attended

	From: MM/YY To MM/YY
University of Massachusetts Medical School	09/93 - 06/98 (including 1 year maternity leave of absence 07/95 - 06/96)

Medical School From Which You Received Your Medical Degree: same

Name of University Affiliation (if applicable): * University of Massachusetts

Street Address: 55 Lake Avenue North

City: Worcester State/Province: MA 01655 Country of citizenship during medical education: USA

Language(s) of Instruction: English

Type of Degree: ☑ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other: _____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month 06 Day 07 Year 98

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☑ I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. ☐ I passed either ☐ the TOEFL **or** ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☐ I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? ☑ NO ☐ YES If "YES," please write or call the Board for additional information.

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a U.S. postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). *If you have not met this requirement, DO NOT submit this appli-*

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education ***after*** successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete 2 years of U.S. postgraduate training. If you have not met this requirement, DO NOT submit this application.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

← orientation began in the last week of June

PG Year #s	Place of Training / Address	Specialty	From (month / year)	To (month / year)	Accredited by
1,2,3	Place of Training: Memorial Hospital of Rhode Island/ Brown University Address: 111 Brewster St Pawtucket, RI 02860	Family Medicine	06 / 98	06 / 01	ACGME ☑ AOA ☐ RCPSC ☐
PG Year #s	Place of Training: Address:	Specialty:	month / year	month / year	ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training: Address:	Specialty:	month / year	month / year	ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training: Address:	Specialty:	month / year	month / year	ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training: Address:	Specialty:	month / year	month / year	ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Initial Medical Licensure HOSPITAL PRIVILEGES 12/2015 INT	Print Your Name: MARI BENTLEY, MD, MPH	Date: 10/30/16	Page 6 of 11

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

	month	year	TO	month	year
Hospital: Boston Medical Center	09	01	TO	present	
Complete Address: 1 BMC Place Boston, MA 02118	Department: Family Medicine				
Hospital:			TO		
Complete Address:	Department				
Hospital:			TO		
Complete Address:	Department				
Hospital:			TO		
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Hospital:			TO		
Complete Address:	Department				
Hospital:			TO		
Complete Address:	Department				

Print Your Name: MARI BENTLEY, MD, MPH Date: 10/30/16

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO ☑ YES ☐

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? NO ☑ YES ☐

If you answered "Yes" to a. **and** b., you must have successfully completed 2 years of ACGME-accredited clinical postgraduate training. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure

a. **State Board Examination List state(s):**_____

STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license.

NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.

NOTE: This section is not relating to National Board Certification.

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☐ FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☑ USMLE Steps 1, 2, and 3: **Successfully passing all parts of the examination.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states:_____, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☑ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
MA	209027	✓					
CT	10906214	✓					
NY	284491-1	✓					
VA	0101261335	✓					
RI	MD 10568		✓				

(If more space is needed, please attach an additional signed and dated sheet.)

16. Check YES or NO.

YES	NO	
☐	☑	Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application? No, I took USMLE Step 3 02/2000
☑	☐	During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada ?
☑	☐	Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada? If "YES," in which specialty were you certified? Family Medicine Date certified 07/2001 07/2008

⇒ If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.

17. Character and Fitness Questions (Check either YES or NO)

	YES	NO	
a.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. Refer to the document *Grounds for Board Action in Maryland* at the Board's website www.mbp.state.md.us.
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f.			Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you commited a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h.			Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i.			Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j.			Do you illegally use drugs?
k.			Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l.			Have you ever been named as a defendant in a medical malpractice action?
m.			Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n.			Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o.			Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p.			Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q.			Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r.			Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»»» If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions: N/A

1. Total number of malpractice claims ever filed in which you were named as a defendant?_____
2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? _____
3. Within the last 60 months (5 years) provide the following:
   Total number of medical malpractice claims filed _____ ; paid (settlement / judgment) _____;
   or dismissed_____; in which you were named as a defendant.
4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

I have attached the following number of pages to this application: Ø

Initial Medical Licensure
RELEASE AND
CERTIFICATION
10/2016

RELEASE AND CERTIFICATION

18. **Release:** I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Federation of State Medical Boards, hospitals, and other licensing bodies. I also agree to sign any subsequent release for information that may be requested by the Board.

Mari Bentley, MD, MPH — Applicant's Name (Printed)

[signature] — Applicant's Signature

11/18/16 — Date

19. **(OPTIONAL) Third Party Release:** The Board encourages you to complete all aspects of your application on your own. If you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

CUSTOMER SERVICE
RECEIVED
NOV 22 2016
BOARD OF PHYSICIANS

Name: _____ **Signature:** _____

Phone: _____ **Date:** _____

E-mail address: _____

20. **Cooperation in an Investigation:** I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

[signature] — Applicant's Signature

11/18/16 — Date

21. **Certification:** To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-20 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board. I also certify that I am thoroughly familiar with the Statute (Title 14) and Code of Maryland Regulations (COMAR) 10.32.01 *et seq. which govern the practice of medicine in Maryland.*

[signature] — Applicant's Signature

11/18/16 — Date

STATE OF Massachusetts, CITY/COUNTY OF Suffolk, I HEREBY CERTIFY that on this 18 day of November, 20 16, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Mari Bentley (print applicant's name), whose likeness is identifiable as that of the individual in the photograph attached to this application and who has made oath in due form of law to be the individual referenced in the above application for license to practice medicine and surgery in Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. [signature] Notary Public

My Commission expires: 07/22/2022

SEAL
KAREN MIRANDA
Notary Public, Commonwealth of Massachusetts
My Commission Expires July 22, 2022

The date the applicant and the notary sign the application must be the same.

RELEASE AND CERTIFICATION

19. Release:
I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

MARI BENTLEY — Applicant's Name (Printed)

[signature] — Applicant's Signature

10/30/16 — Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release. Please know that without this release, no one will be able to receive information concerning your file.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name:

Phone:

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

[signature] — Applicant's Signature

10/30/16 — Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

[signature] — Applicant's Signature

10/30/16 — Date

STATE OF Massachusetts

CITY/COUNTY OF Suffolk

I HEREBY CERTIFY that on this 31 day of October, 20 16, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Mari Bentley (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. [signature]
Notary Public

My Commission expires: 07/22/2022

KAREN MIRANDA
Notary Public, Commonwealth of Massachusetts
My Commission Expires July 22, 2022

*** Applicant signature date and notary signature date should be the same.**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

November 02, 2016

Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215-0095

TO WHOM IT MAY CONCERN:

VERIFICATION OF LICENSURE

This is to certify that the records of the Connecticut Department of Public Health indicate that:

MARI BENTLEY, MD

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	10/19/2016
License Number:	55837
Expiration Date:	09/30/2017
Status of License:	ACTIVE, CURRENT
Past or Pending Disciplinary History:	No

Disciplinary History

Past or pending public disciplinary action:

There has been no public disciplinary action	X
Public action taken, see attached	_____

Past or pending confidential action taken:

There has been no confidential disciplinary action	X
Complaint under investigation, see attached	_____
Confidential action taken, see attached	_____
Other, see attached	_____

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
Practitioner Licensing and Investigations Section

Printed by: Angela Holmes

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
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Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

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Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary
Health and Human Services

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Public Member

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Physician Member

GEORGE ABRAHAM, MD
Physician Member

GEORGE ZACHOS, ESQ
Executive Director

11/2/2016

To Whom It May Concern:

This certifies that Mari J Bentley, M.D., a 1998 graduate of University of Massachusetts Medical School, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 209027 was issued to Dr. Bentley on 01/24/2001. The license status is: Active. The expiration date is 9/2/2017.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

Francee L Mulero

SEAL

Staff Member, Board of Registration in Medicine

Francee Mulero

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, BENTLEY MARI MANSFIELD
was issued license/certificate number 284491 for the practice of MEDICINE on 05/19/16.

Our records also indicate the following information:
Date of birth: 09/02/66
School attended: UNIVERSITY OF MASS
Date of graduation: 06/07/98
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
02/00									0000
03/98						0000P			
06/95			0000P						

CUSTOMER SERVICE
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NOV 21 2016
BOARD OF PHYSICIANS

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 04/30/18
Address: APT 1 127 FULLER ST
BROOKLINE MA 02446-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Cathy Hanczaryk 11/14/16
Office Assistant Three