

## Hodge, Lakesha D

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**From:** Bri Anne McKeon <bri.anne.mckeon@gmail.com>  
**Sent:** Tuesday, January 23, 2018 2:40 PM  
**To:** Hodge, Lakesha D  
**Subject:** Re: Florida Board of Medicine File# 136648

Hi La'Kesha:

Thank you for the email. I will work on the included requests and be back in touch shortly.

In response to the question: Have you completed courses in Biology, Anatomy and Chemistry? The answer is YES.

I will be in touch shortly regarding the additional requested documents.

Thank you,

Bri Anne McKeon

On Tue, Jan 23, 2018 at 9:57 AM, Hodge, Lakesha D <[Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov)> wrote:

Greetings,

My name is La'Kesha Hodge, your licensure processor at the Florida Board of Medicine. I will be handling the processing of your application until your file is deemed complete.

I have reviewed your application and your deficiency letters are attached in this email as a courtesy to expedite your application process.

Please note that I am unable to accept postgraduate training verifications, medical school verifications, examination scores, and ECFMG verifications from applicants. Please ask the entities to email or fax me your verifications, directly. My fax number is listed below. This will assist in expediting your licensure process as well. Also, if you upload any documentation after receiving this email, please send an email stating that you have uploaded documentation to your file. This will also assist in expediting your licensure process.

Please check your on-line status on Fridays for weekly updates. If your status has not changed within two weeks and you are certain that I should have received some of the listed deficient documents, kindly send me an email.

I hope you will find this email helpful and informative. If you have any questions please feel free to contact me at your convenience.

Best,

*La'Kesha Hodge*

La'Kesha Hodge

Regulatory Specialist II

Department of Health (DOH) | Division of Medical Quality Assurance (MQA)

Board of Medicine

Phone: [\(850\) 617-1909](tel:8506171909) | Fax: [\(850\) 412-1273](tel:8504121273)

4052 Bald Cypress Way, # C-03 | Tallahassee, FL 32399-3256

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--

Bri Anne McKeon, MD

# 11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at [www.nica.com](http://www.nica.com). Check only one.

\$5,000  
Participating

\$250  
Non-participating

\$0  
Exempt

0  
Amount enclosed

If you choose "\$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

*Brittany Mcken*  
Signature

1/24/18  
Date

Brittany Mcken, MD  
Name  
492 Beacon St #23  
Street Address  
Boston, MA, 02115  
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine  
4052 Bald Cypress Way, #C-03  
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA  
2360 Christopher Place  
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at [www.nica.com](http://www.nica.com) or (850) 488-8191.



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

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

Recipient:

Date:

01/23/2018

FLORIDA BOARD OF MEDICINE

Examinee: McKeon, Bri Anne

Examinee ID: 52447273

Alt Name(s):

Date of Birth: 11/26/1985

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

## USMLE STEP 1

| Test Date | Pass/Fail | Total      | MP    | Comments |
|-----------|-----------|------------|-------|----------|
| 6/17/2010 | Pass      | [REDACTED] | (188) |          |

## USMLE STEP 2

### Clinical Knowledge (CK)

| Test Date | Pass/Fail | Total      | MP    | Comments |
|-----------|-----------|------------|-------|----------|
| 7/29/2011 | Pass      | [REDACTED] | (189) |          |

### Clinical Skills (CS)\*

| Test Date  | Pass/Fail | Total | MP | Comments |
|------------|-----------|-------|----|----------|
| 12/14/2011 | Pass      |       |    |          |

## USMLE STEP 3

| Test Date | Pass/Fail | Total      | MP    | Comments |
|-----------|-----------|------------|-------|----------|
| 7/30/2013 | Pass      | [REDACTED] | (190) |          |

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



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Examinee: McKeon, Bri Anne

Examinee ID: 52447273

Date of Birth: 11/26/1985

## INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

## STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

## ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

**Indeterminate** - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

**Incomplete** - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

**Irregular Behavior** - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

**Score Not Available** - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

## ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

## PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

*This document was printed from a secure website and accurately reflects score information maintained by the FSMB.*

*Blauys  
Heska*

# POST-GRADUATE TRAINING VERIFICATION FORM

MEDICINE BOARD

18 JAN 30 AM 11 39

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE  
4052 BALD CYPRESS WAY, BIN C-03  
TALLAHASSEE, FLORIDA 32399-3253  
(850) 412-1268 Facsimile

BETH ISRAEL DEACONESS MEDICAL CENTER  
Name of School

OBSTETRICS & GYNECOLOGY  
Department

330 BRADLINE AVE. E/VS 3  
Address

BOSTON, MA 02115  
City, State, Zip

**ORIGINAL**

1. Name of Resident: BRI ANNE MCKEAN, MD

2. Internship/Residency/Fellowship: From: 06.18.2012 To: 06.17.2016

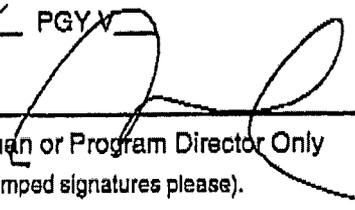
3. Matriculation Date: 06.18.2012

4. Completion Date: 06.17.2016

5. Specialty: OBSTETRICS & GYNECOLOGY

6. Levels completed (check all that apply):

PGY I  PGY II  PGY III  PGY IV  PGY V

Signed:   
Chairman or Program Director Only  
(No stamped signatures please).



Beth Israel Deaconess  
Medical Center



A teaching hospital of  
Harvard Medical School

Department of Obstetrics  
& Gynecology  
Residency Program

Monica Mendiola, MD  
Program Director

Brianne Mahoney, MD  
Assistant Program Director

Co-Director, Resident  
Ambulatory Practice

Siripanth Nippita, MD, MS  
Assistant Program Director

Ryan Program Director &  
Rotation Director, Family  
Planning

Martina DiNapoli  
Residency Program  
Coordinator

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## facsimile transmittal

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To: Florida Board of Medicine      Fax No.: (850) 412-1268  
 From: Monica Mendiola, MD      Contact: Martina N. DiNapoli  
 Date: 1.29.2018      No. of Pages: 2  
 Re: Bri Anne McKeon, MD

Urgent     For review     Please comment     Please reply     Please recycle

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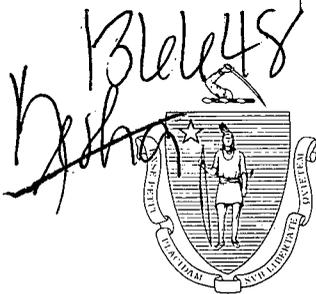
**Notes:**

*This facsimile transmission is intended for the use of the person(s) to whom it may be addressed. It may contain information that is privileged, confidential or otherwise protected from disclosure under applicable law. If you are not the intended recipient, any dissemination, distribution, copying, or use of this information is prohibited. If you have received this facsimile transmission in error, please notify us immediately by telephone, during which time we can arrange for return of attached documents (if necessary). Thank you.*

330 Brookline Avenue  
Kirstein 3  
Boston, MA 02215

(617) 667-2285  
Fax# (617) 667-0842  
mdnapol@bidmc.harvard.edu

3326812



# Commonwealth of Massachusetts Board of Registration in Medicine

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

CANDACE LAPIDUS SLOANE, MD  
Chair, Physician Member  
KATHLEEN SULLIVAN MEYER, ESQ.  
Vice Chair, Public Member

[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

Enforcement Division Fax: (781) 876-8381  
Legal Division Fax: (781) 876-8380  
Licensing Division Fax: (781) 876-8383

MICHAEL HENRY, MD  
Secretary, Physician Member  
JULIAN N. ROBINSON, MD  
Physician Member

WOODY GIESSMANN, LADC-I, CADC, CIP, CAI  
Public Member

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GEORGE ABRAHAM, MD  
Physician Member

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Governor  
KARYN E. POLITO  
Lieutenant Governor  
MARYLOU SUDDERS  
Secretary  
Health and Human Services  
MONICA BHAREL, MD, MPH  
Commissioner  
Department of Public Health

**ORIGINAL**

1/31/2018

To Whom It May Concern:

This certifies that Bri A McKeon, M.D., a 2012 graduate of University of Florida College of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 265886 was issued to Dr. McKeon on 04/07/2016. The license status is: Active. The expiration date is 11/26/2018.

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](http://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.

18 FEB -5 0911100  
MEDICINE BOARD

SEAL

*Francee L Mulero*  
Staff Member, Board of Registration in Medicine  
Francee Mulero

## Hodge, Lakesha D

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**From:** Gilder, Julian <jgilder@ufl.edu>  
**Sent:** Tuesday, February 20, 2018 1:37 PM  
**To:** Hodge, Lakesha D  
**Cc:** 'Bri Anne McKeon'  
**Subject:** Verification of Medical Education  
**Attachments:** McKeon Bri.pdf

Greetings,

Attached, please find the medical degree verification form for Dr. McKeon. I will send the original form with embossed seal via mail. Hopefully, it will reach you this time.

Best regards,  
Julian Gilder



**Julian Gilder | Registrar, College of Medicine**

UF College of Medicine  
Office of Student Affairs and Registration  
P.O. Box 100216  
1104 Newell Drive – Building #214  
Gainesville, FL 32610  
Room 210  
Phone (352-273-7978)  
Fax (352-273-7536)

## Medical Degree Verification Form

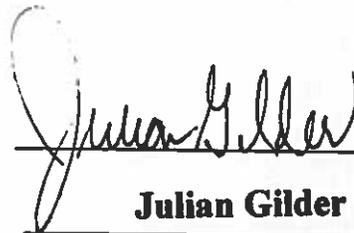
FLORIDA BOARD OF MEDICINE  
4052 BALD CYPRESS WAY, BIN # C03  
TALLAHASSEE, FL 32399-3253  
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: University of Florida College of Medicine  
Name of medical school  
1600 SW Archer Road, M509  
Street address  
Gainesville, FL, 32610, USA  
City - State - Zip - Country
  
2. Name: Bri Anne McLean, MD
  
3. Date of Birth: 11/26/85
  
4. Type of Degree: MD Date Degree Received: 05/19/2012

Authenticate by signature and school seal.

SEAL



Verified by

**Julian Gilder**

**Assistant University Registrar**

Name

Title

## Hodge, Lakesha D

---

**From:** Bri Anne McKeon <bri.anne.mckeon@gmail.com>  
**Sent:** Saturday, February 24, 2018 1:58 PM  
**To:** Hodge, Lakesha D  
**Subject:** Re: Florida Board of Medicine File# 136648  
**Attachments:** NPDBQuery\_McKeon.pdf

Hi Lakesha:

I have attached my NPDB report. I believe this should complete my application.

Thank you

Bri Anne McKeon

On Mon, Feb 19, 2018 at 2:36 PM, Hodge, Lakesha D <[Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov)> wrote:

Greetings,

Thank you for your email. Your on-line status has been updated. Please review your online status and contact me if you have any additional questions. Thanks!

Best,

*La'Kesha Hodge*

La'Kesha Hodge

Regulatory Specialist II

Department of Health (DOH) | Division of Medical Quality Assurance (MQA)

Board of Medicine

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[4052 Bald Cypress Way, # C-03](#) | Tallahassee, FL 32399-3256

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**From:** Bri Anne McKeon [mailto:[bri.anne.mckeon@gmail.com](mailto:bri.anne.mckeon@gmail.com)]

**Sent:** Monday, February 19, 2018 11:22 AM

**To:** Hodge, Lakesha D <[Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov)>

**Subject:** Re: Florida Board of Medicine File# 136648

Hi Lakesha:

I wanted to check on the status of my Florida Medical License Application.

Online it states that I still have the following deficiencies:

1. [Exam Scores not received](#)
2. [License verification not received](#)
3. [Medical school inquiry not received](#)
4. [NPDB report not received](#)

These have all been requested and should have been mailed.

Can you please send me any update?

Thank you,

Bri Anne McKeon

On Mon, Jan 29, 2018 at 8:40 AM, Hodge, Lakesha D <[Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov)> wrote:

Greetings,

Received; thank you.

Best,

*Lakesha Hodge*

La'Kesha Hodge

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**Sent:** Wednesday, January 24, 2018 5:45 PM  
**To:** Hodge, Lakesha D <[Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov)>  
**Subject:** Re: Florida Board of Medicine File# 136648

Hi La'Kesha:

My NICA form is attached for my FL medical license application. Please confirm receipt. I have requested the others and will be back in touch when I receive them (or you should receive some directly)

Thank you,

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Please check your on-line status on Fridays for weekly updates. If your status has not changed within two weeks and you are certain that I should have received some of the listed deficient documents, kindly send me an email.

I hope you will find this email helpful and informative. If you have any questions please feel free to contact me at your convenience.

Best,

*La'Kesha Hodge*

La'Kesha Hodge

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Board of Medicine

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Focus: To be the nation's leader in quality health care regulation.

Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

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Bri Anne McKeon, MD

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**Celeste Philip, MD, MPH**  
Surgeon General and Secretary

**Vision:** To be the **Healthiest State** in the Nation

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February 27, 2018

Bri Anne McKeon, M.D.  
492 Beacon Street  
Apt #23  
Boston, MA 02115

Dear Dr. McKeon:

Congratulations! You have completed the application process for licensure as a Medical Doctor in the State of Florida. Your license number is ME 135450. You will receive your printed license within two weeks. Within 24 hours, you can verify your license online at [www.FLHealthSource.gov](http://www.FLHealthSource.gov).

The current license biennium expires 01/31/2020. It is your obligation to complete any continuing education (CE) that is required. You must have completed the required CEs prior to renewing your license. Visit [www.FLHealthSource.gov/AYRR](http://www.FLHealthSource.gov/AYRR) and become familiar with the renewal process. Your CE requirements can be found at [www.FLHealthSource.gov/requirements](http://www.FLHealthSource.gov/requirements).

Licenses are renewed on a biennial basis. Approximately 90 days prior to the expiration date shown on your license, a postcard reminder will be mailed to the last known address on file for you. The U.S. Post Office does NOT forward state mail. Address changes may be submitted electronically through your MQA Online Services Portal account. If you have not registered for an account in the new system, go to [www.FLHealthSource.gov/mqa-services](http://www.FLHealthSource.gov/mqa-services) and select "No" to get started. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User.

**Practitioner Profile** – In carrying out the legislative mandate to publish practitioner profiles, we want to ensure the information that we publish is accurate. You should receive your license within two weeks, which will include your User ID and Password. Please confirm your practitioner profile by accessing your account using your User ID and Password or by using the Alternate Login process at <http://www.flhealthsource.gov/>, and selecting "Update/Confirm Your Profile Online" from the Practitioner Profile dropdown menu. You can review, confirm, or make changes to the information that will be published in your practitioner profile. If you see the statement "The practitioner did not provide this mandatory information", please provide that information. We will not accept curriculum vitae or resumes in place of you providing specific information. Changes, excluding education and training, year began practicing, and liability claims, can be made to your profile electronically. You may also submit changes by mail to the Department of Health, Licensing and if you have questions, please call (850) 488-0595, option 3, Monday through Friday, 8:00 a.m. to 5:00 p.m., EST. You may also email us at [mqalicensureservices@flhealth.gov](mailto:mqalicensureservices@flhealth.gov).

According to section 456.041(7), Florida Statutes, you have thirty (30) days from receipt of this letter to submit changes to the department. If you do not make changes within thirty (30) days, your profile will be automatically published.

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX : (850) 488-0596



**Accredited Health Department**  
Public Health Accreditation Board

Thank you for applying for licensure in Florida. If you have additional questions, you may contact the board office at (850) 245-4131 or at the address listed below.

Welcome to Florida,

Board of Medicine Staff

AC# **COPY**

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH  
DIVISION OF MEDICAL QUALITY ASSURANCE**

| DATE       | LICENSE NO. | CONTROL NO. |
|------------|-------------|-------------|
| 02/28/2018 | ME 135450   | 623720      |

The **MEDICAL DOCTOR** named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: **JANUARY 31, 2020**

**BRI ANNE MCKEON  
330 BROOKLINE AVENUE  
BOSTON, MA 02215**

|   |             |             |
|---|-------------|-------------|
| STATE OF FLORIDA<br>DEPARTMENT OF HEALTH<br>DIVISION OF MEDICAL QUALITY ASSURANCE | AC#         |             |
| DATE  | LICENSE NO. | CONTROL NO. |
| 02/28/2018  | ME 135450   | 623720      |

The **MEDICAL DOCTOR** named below has met all requirements of the laws and rules of the state of Florida.  
Expiration Date: **JANUARY 31, 2020**

**COPY - NOT A VALID LICENSE - COPY**

LICENSEE SIGNATURE

**COPY - NOT A VALID LICENSE - COPY**

GOVERNOR

Surgeon General and Secretary

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2020**

Your license number is ME 135450. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit [www.FLHealthSource.gov](http://www.FLHealthSource.gov) and click "Renew A License" to renew online.

Medical Quality Assurance has a new and improved Online Services Portal. In the new system, you have the ability to renew your license, update your mailing and practice location addresses, request a name change, request a duplicate license and update your profile information all from the convenience of your online account.

1. Go to [www.FLHealthSource.gov](http://www.FLHealthSource.gov).
2. Click on "Provider Services" and select "Manage Your License."
3. Select your profession and license type and click "Submit."
4. The question "Have you Registered in Our New Online Service S
  - a. Click on "No" if you have not registered for an account in the new system and follow the instructions provided for new user registration.
  - b. Click on "Yes" if you are a returning user. Enter the user ID and password you selected during the registration process, then select "Sign In" to access your MQA Online Services Portal account.

**IMPORTANT ANNOUNCEMENTS**

Are You Renewal Ready?

The Department of Health will now review your continuing education records at the time of license renewal.

To learn more, please visit [www.FLHealthSource.gov/AYRR](http://www.FLHealthSource.gov/AYRR)

Grounds for Discipline

You should be familiar with the Grounds for Discipline found in Section 456.072(1), Florida Statutes, and in the practice act for the profession in which you are licensed.

Florida Statutes can be accessed at [www.leg.state.fl.us/Statutes](http://www.leg.state.fl.us/Statutes)

DEPARTMENT OF HEALTH  
DIVISION OF MEDICAL QUALITY ASSURANCE  
LICENSURE SUPPORT SERVICES UNIT  
4052 BALD CYPRESS WAY, BIN #C-10  
TALLAHASSEE, FLORIDA 32399-3260



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\*\*\*\*\* **AUTO** \*\*\*\*\*

**BRI ANNE MCKEON  
492 BEACON STREET  
APT #23  
BOSTON, MA 02115**

**COPY**

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**COPY - NOT A VALID LICENSE - COPY**

**COPY - NOT A VALID LICENSE - COPY**

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135450

3337015

### Medical Degree Verification Form

MEDICINE BOARD  
18 FEB 27 AM 9:47

FLORIDA BOARD OF MEDICINE  
4052 BALD CYPRESS WAY, BIN # C03  
TALLAHASSEE, FL 32399-3253  
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: University of Florida College of Medicine  
Name of medical school  
1600 SW Archer Road, M509  
Street address  
Gainesville, FL, 32610, USA  
City - State - Zip - Country

2. Name: Bri Anne McLean, MD

3. Date of Birth: 11/26/85

4. Type of Degree: MD Date Degree Received: 05/19/2012

ORIGINAL

Authenticate by signature and school seal.

SEAL

Julian Gilder  
Verified by  
**Julian Gilder**  
Name  
**Assistant University Registrar**  
Title

Division

22/11/2013

D.M.

Julian Gilbert

Assistant University Registrar

Handwritten notes at the bottom right of the page.

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**Celeste Philip, MD, MPH** Surgeon  
General and Secretary  
State Surgeon General & Secretary

Vision: To be the **Healthiest State** in the Nation

## Application Summary

### Application Detail

|                    |   |
|--------------------|---|
| License Type:      | <b>Medical Doctor</b>                         |
| Profession Number: | <b>1501 - Medical Doctor</b>                  |
| File Number:       | <b>136648</b>                                 |
| Application:       | <b>Medical Doctor Endorsement Application</b> |
| Application Date:  | <b>01/18/2018</b>                             |

### Application Questions

|   |            |
|---|------------|
| Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.   | <b>No</b>  |
| I am designating as NICA Non-Participating  | <b>Yes</b> |
| I will qualify for "In Training" status at the approval of my licensure application.  | <b>No</b>  |
| I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is \$100.00 over and above the required initial license fee and will submit it along with the license fee. | <b>No</b>  |
| I completed a board approved post-graduate training program within the last two years or have practiced medicine in another jurisdiction for two of the last four years.  | <b>Yes</b> |
| Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.   | <b>No</b>  |

### Personal Detail

|                     |             |
|---------------------|-------------|
| Title:              | <b>Dr.</b>  |
| First Name:         | <b>Bri</b>  |
| Middle/Second Name: | <b>Anne</b> |

Last Name/Surname: **McKeon**  
Birthdate: **11/26/1985**  
Gender: **Female**  
Race: **White**  
Social Security Number: **[REDACTED]**

### Addresses

#### Mailing Address

Address: **492 Beacon Street**  
**Apt #23**  
**Out of State**  
**Boston, MA**  
**02115**  
**US**

Phone Number: **813-505-0925**

Extension:

E-mail Address: **bri.anne.mckeon@gmail.com**

Home

Fax

#### Place of Practice

Address: **330 Brookline Avenue**  
**Out of State**  
**Boston, MA**  
**02215**  
**US**

Phone Number: **617-667-4600**

Extension:

### Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials? **No**

### Education History

School Name: **UNIVERSITY OF FLORIDA**

Street Address Line 1: **1600 SW Archer Road**

Street Address Line 2: **M509**

City: **Gainesville**

State: **FLORIDA**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Postal/Zip:                      | <b>32610</b>                    |
| Country:                         | <b>UNITED STATES OF AMERICA</b> |
| Date of Graduation (mm/dd/yyyy): | <b>05/19/2012</b>               |
| Attended From (mm/dd/yyyy):      | <b>08/01/2008</b>               |
| Attended To (mm/dd/yyyy):        | <b>05/19/2012</b>               |

#### **Additional Education Questions**

Are you currently in default on any health education loan or scholarship obligation? **No**

Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school? **No**

#### **Fifth Pathway**

Did you attend an international medical school and do not possess a valid ECFMG Certificate? **No**

Did you receive a bachelor's degree from an accredited United States college or University? **No**

Did you study at a medical school which is recognized by the World Health Organization? **No**

Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent? **No**

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent? **No**

#### **Postgraduate Training 1**

Program Name: **Beth Israel Deaconess Medical Center**

Mailing Address: **330 Brookline Avenue  
Kirstein 3**

Program City: **Boston**

Program State or Country: **MASSACHUSETTS**

Program Type: **INTERNSHIP**

Specialty Area: **OBG - OBSTETRICS AND GYNECOLOGY**

Attended From (mm/dd/yyyy): **06/18/2012**

Attended To (mm/dd/yyyy): **06/30/2013**

Did you receive credit? **Yes**

### Postgraduate Training 2

Program Name: **Beth Isreal Deaconess Medical Center**

Mailing Address: **330 Brookline Avenue  
Kirstein 3**

Program City: **Boston**

Program State or Country: **MASSACHUSETTS**

Program Type: **RESIDENCY**

Specialty Area: **OBG - OBSTETRICS AND GYNECOLOGY**

Attended From (mm/dd/yyyy): **07/01/2013**

Attended To (mm/dd/yyyy): **06/17/2016**

Did you receive credit? **Yes**

### Exam History

Examination: **National Board**

Date Passed (mm/dd/yyyy): **07/30/2013**

### United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service? **No**

Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service? **No**

### Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **265886**

Profession: **Medicine**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **MASSACHUSETTS**

### Additional Employment Questions

Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

### Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

### Initial Graduate Medical Education Responsibility and Faculty Appointments 1

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution:

**BETH ISRAEL DEACONESS MEDICAL CENTER**

### **Initial Graduate Medical Education Responsibility and Faculty Appointments 2**

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution:

**HARVARD MEDICAL SCHOOL**

### **Staff Privileges 1**

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility:

**OUT OF STATE**

Out of State Facility:

**Beth Israel Deaconess Medical Center**

### **Staff Privileges 2**

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility:

**OUT OF STATE**

Out of State Facility:

**Beth Israel Deaconess Hospital-Milton**

### **Specialty Board Certifications**

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

### **DEA**

Have you ever been denied, or surrendered, a DEA registration? **No**

### **Criminal History**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

### **Medicaid / Medicare**

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **No**

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? **No**

### Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?

### Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation. **Yes**

Enter in today's date **01/18/2018**

### Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? **No**

### Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000.00? **No**

### Financial Responsibility/Exemption

Financial Responsibility **4. LIABILITY NOT LESS THAN \$250,000**

### FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility? **No**

### FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? **No**

### FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country? **No**

### FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? **No**

### Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? **No**

### Year Began Practice

Year Began Practice: **06/18/2012**

### Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? **Yes**

### Practice Employment

Place of Employment: **Harvard Medical Faculty Physicians at BIDMC**

Address Line 1: **330 Brookline Avenue**

City: **Boston**

State: **MA**

Type of Employment: **Attending Physician**

Begin Date (mm/dd/yyyy): **09/01/2016**

End Date (mm/dd/yyyy): **01/18/2018**

If 'to present', enter today's date.

### **Fees**

|                     |                 |
|---------------------|-----------------|
| Application         | <b>\$350.00</b> |
| Unlicensed Activity | <b>\$5.00</b>   |
| NICA Fee            | <b>\$250.00</b> |
| Initial License     | <b>\$350.00</b> |
| Total Amount Due:   | <b>\$955.00</b> |

### **Attestation**

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**Celeste Philip, MD, MPH**  
Surgeon General and Secretary

**Vision:** To be the **Healthiest State** in the Nation

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**Dr. Bri Anne Mckeon**

**Date: January 23, 2018**

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REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

**YOUR APPLICATION'S EXPIRATION DATE IS JANUARY 17, 2019**

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**APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:**

1. Please complete the attached NICA form and return it to our office. No additional fees are required.
2. Yes or No: Have you completed courses in anatomy, biology, and chemistry? You may email your response to [Lakesha.hodge@flhealth.gov](mailto:Lakesha.hodge@flhealth.gov).
3. Direct primary source verification from your medical school has not been received. Contact your medical school and ask them to either complete the FLBOM Medical School Verification form or to address a letter to the Florida Board of Medicine providing your dates of attendance, the date you graduated and the degree you received. Once completed, ask them to mail the form to 4052 Bald Cypress Way, BIN#C03, Tallahassee, FL 32399; or email it to [Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov).
4. Direct verification of your NBME Examination results has not been received. Please contact the National Board Score Report at 215-590-9500 or visit them on-line at [www.nbme.org](http://www.nbme.org) to obtain your results. Please keep in mind that Florida requires primary source verification, therefore, this document must come directly from the entity.
5. Your Postgraduate Training Verification form has not been received. Please be advised that Florida requires primary source verification, therefore, the verification will not be accepted if it's not submitted by the entity or the Federal Credentialing Verification Service. Your Program Director has the option of completing the Postgraduate Verification form (located in the PDF version of the FL Board Medical Licensure application), or, they may address a letter to the Florida Board of Medicine stating your beginning date, ending date, and the PGY Levels you have completed. Postgraduate Training Certificates will not suffice. This document cannot be uploaded. Please ask the following entities to submit verification of your training:  
Beth Israel Deaconess Medical Center 12-13  
Beth Israel Deaconess Medical Center 13-16
6. An official verification of your medical license from Massachusetts has not been received. Please contact the medical board(s) and request that a verification of your license be submitted to the Florida Board of Medicine. Our address is 4052 Bald Cypress Way, BIN#C03, Tallahassee, FL 32399-3253. A copy of your medical license will not suffice. Florida requires primary source verification, therefore, this document must be sent directly from the entity with the exception of the Indiana and Kentucky verification – the applicant may submit these verifications, only. The applicant may not print a verification from the medical

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX: (850) 488-0596



board's website as this is not considered primary source verification. License verifications received from [www.veridoc.org](http://www.veridoc.org) are acceptable. Remember, Florida requires verification of all full unrestricted medical license you have held in your lifetime; thus, all expired/lapsed and inactive license must be verified.

7. Please submit a copy of your National Practitioner Data Bank Report (NPDB) to our office. NPDB can be reached at 1-800-767-6732 or visit their website at [www.npdb.hrsa.gov/](http://www.npdb.hrsa.gov/) to obtain the report. If you opt to receive the printed copy versus the PDF, please open the sealed envelope and email, fax, or mail the document to our office. If you opt to mail the report, mail it to The Department of Health, 4052 Bald Cypress Way, BIN#C03, Tallahassee, FL 32399. If you opt to print the PDF version, please email me a copy to expedite your licensure process. Please do not remove any pages from the report. Submit the document just as you received it.

If you have any questions, please contact me at [Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov), call 850-617-1909, or fax (850) 412-1273. The Florida Board of Medicine has assigned **136648** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

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**Rick Scott**  
Governor

**Celeste Philip, MD, MPH**  
Surgeon General and Secretary

**Vision:** To be the **Healthiest State** in the Nation

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January 23, 2018

Bri Anne Mckeon, M.D.  
492 Beacon Street  
Apt #23  
Boston, MA 02115

Dear Dr. Mckeon:  
File: 136648

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: [www.FLHealthSource.gov/mqa-services](http://www.FLHealthSource.gov/mqa-services). If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

**THIS IS IMPORTANT:** Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at [Lakesha.Hodge@flhealth.gov](mailto:Lakesha.Hodge@flhealth.gov), call 850-617-1909, or fax (850) 412-1273.

Sincerely,

*Lakesha Hodge*

Lakesha Hodge  
Regulatory Specialist II

Enclosure(s)

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX : (850) 488-0596



**Accredited Health Department**  
Public Health Accreditation Board