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JAN 22 2016
Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

McKeon | Bri | Anne | |
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ PhD ☐ Other degree_____ ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here. ☒

Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

Social Security Number: ___ ___ ___ Date of Birth: ___ ___ ___
Month Day Year

NPI (National Provider Identifier) Number: 1730441486

Place of Birth: ___
City | State/Province/Territory | Country if not USA

*Mailing Address: ___ Telephone: ___
Number and Street

___
City | State/Province/Territory | Zip (or postal) Code

Home Address: ___ Telephone: ___
Number and Street

___
City | State/Province/Territory | Zip (or postal) Code

Business Address: 330 Brookline Avenue, Kirsten 3 Telephone: 617-667-2285
Number and Street

Boston | MA | 02215
City | State/Province/Territory | Zip (or postal) Code

E-mail Address: ___ Fax number: 617-667-0842

Are you applying for licensure through FCVS? ☐ **Yes** ☒ **No**

*** The Board will use your Mailing Address for all correspondence**

Pre-medical School | From | To

Name: University of North Carolina Degree: BS Year: 2004 Year: 2008
Street: 103 South Building City: Chapel Hill State: NC

Name: _____ Degree: _____ Year: _____ Year: _____
Street: _____ City: _____ State: _____

Medical School

Name: University of Florida College of Medicine Degree: MD
Street: P.O. Box 100215 City: Gainesville State: FL

Name: _____ Degree: _____
Street: _____ City: _____ State: _____

Medical School Graduation Date: 05 (Month) / 2012 (Year)

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

		From	To
Facility: Beth Israel Deaconess Medical Center	PGY Year: 1	06 / 2012	06 / 2013
Specialty: Obstetrics and Gynecology	City: Boston	State: MA	
Facility: Beth Israel Deaconess Medical Center	PGY Year: 2	07 / 2013	06 / 2014
Specialty: Obstetrics and Gynecology	City: Boston	State: MA	
Facility: Beth Israel Deaconess Medical Center	PGY Year: 3	07 / 2014	06 / 2015
Specialty: Obstetrics and Gynecology	City: Boston	State: MA	
Facility: Beth Israel Deaconess Medical Center	PGY Year: 4	07 / 2015	06 / 2016
Specialty: Obstetrics and Gynecology	City: Boston	State: MA	
Facility: _____	PGY Year: _____	/	/
Specialty: _____	City: _____	State: _____	

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	1	☒ P ☐ F
USMLE Step II	1	☒ P ☐ F
USMLE Step III	1	☒ P ☐ F
NBME Part I		☐ P ☐ F
NBME Part II		☐ P ☐ F
NBME Part III		☐ P ☐ F
FLEX Component 1		☐ P ☐ F
FLEX Component 2		☐ P ☐ F
FLEX Pre-1985		☐ P ☐ F
NBOME Part I		☐ P ☐ F
NBOME Part II		☐ P ☐ F
NBOME Part III		☐ P ☐ F
COMLEX Level 1		☐ P ☐ F
COMLEX Level 2		☐ P ☐ F
COMLEX Level 3		☐ P ☐ F
COMVEX		☐ P ☐ F
LMCC – Single		☐ P ☐ F
LMCC – Part I		☐ P ☐ F
LMCC – Part II		☐ P ☐ F
State Board Exam	(State of examination and year)	☐ P ☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility:_____	Position:_____	___/___	___/___
Street:_____	City:_____	State:_____	
Facility:_____	Position:_____	___/___	___/___
Street:_____	City:_____	State:_____	
Facility:_____	Position:_____	___/___	___/___
Street:_____	City:_____	State:_____	

1. List other states (abbreviations) where you are currently or have ever had a full license: N/A

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s):_____

4. List your practice specialt(ies): Obstetrics and Gynecology

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? ☒ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)

7. Reason for requesting a Massachusetts medical license: Joining Harvard Medical Faculty Physicians as attending Obstetrician-Gynecologist

8. Name of Facility: Beth Israel Deaconess Medical Center
   Address: 330 Brookline Avenue City: Boston

9. Anticipated starting date in Massachusetts: 09 / 01 / 2016

10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature of Applicant

01 / 15 / 2016
Month Day Year

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Bri Anne McKean, MD
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Bri Anne McKean MD
Applicant's Signature

01/15/16
Date of Signature

McKean, Bri, Anne
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

Commonwealth of Massachusetts – Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, Bri Anne McKean, MD,
(type or print name)

certify, under the penalties of perjury, to the best of my knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: Bri Anne McKean MD DATE: 12/15/2015

Social Security Number: ____ _____

****

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

I will not charge to, or collect from, a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: Bri Anne McKean MD DATE: 12/15/2015

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

____ Participation in a Meaningful Use program as an eligible professional;
__✓__ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: [illegible] MD DATE: 1/4/2016

Harvard Medical School Curriculum Vitae

Date Prepared: 01/15/2016

Name: Bri Anne McKeon, MD

Office Address: 330 Brookline Avenue, Kirstein 3, Boston, MA 02215

Home Address:

Work Phone: 617-667-3736

Work Email:

Work FAX: 617-667-4173

Place of Birth:

Education

8/24/04-5/11/08	B.S., B.A. *magna cum laude*	Biology and Spanish, Chemistry Minor	University of North Carolina- Chapel Hill
8/18/08-5/19/12	M.D.	Medicine	University of Florida College of Medicine

Postdoctoral Training

06/18/12-present	Resident	Obstetrics and Gynecology	Beth Israel Deaconess Medical Center

Committee Service

Local

2008-2012	Class of 2012 Executive Board 2008-2012	University of Florida College of Medicine Historian
2014-present	Beth Israel Deaconess Medical Center Academy of Medical Educators	Associate Academy Member
2014-present	Beth Israel Deaconess Medical Center Gold Humanism Society	Member-at-large (2014-2015) Co-Chair of Humanistic Environment Committee (2015-2016)
2015-2016	Beth Israel Deaconess Medical Center Obstetrics & Gynecology Residency	Co-Administrative Chief Resident

Professional Societies

2008-	American Medical Association	Member
2011-	American College of Obstetricians and Gynecologists	Member

Honors and Prizes

2005	Membership	National Society of Collegiate Scholars	
2007	Sterling Stoudemire Medal for Excellence in Spanish	Department of Romance Languages, University of North Carolina-Chapel Hill	
2007	Membership	Phi Beta Kappa	
2008, 2009, 2010	Certificate for Exemplary Performance in Essentials of Patient Care	University of Florida College of Medicine	
2011	Lawrence M. Goodman Research Award	University of Florida Medical Student Research Program	Presented to an exceptional student research project at the University of Florida Medical Student Research Day
2011	Membership	Chapman Chapter of the Gold Humanism Honor Society	
2012-2013, 2013-2014	Outstanding Resident Teaching Award	Harvard Medical School BIDMC Principal Clinical Experience (PCE)	Awarded to residents who worked with 3rd year Harvard Medical students during clinical rotations and exhibited excellence in teaching
2014	CREOG PGY2 Teaching Award	BIDMC Obstetrics & Gynecology Residency	Awarded to the PGY2 selected by the PGY1 as having the strongest commitment to resident education
2015	Research Poster Award for Curriculum Innovation	Harvard Medical School Medical Education Day	

Report of Funded and Unfunded Projects

2009 International Summer Research Program in Peru
Medical Student Research Program (MSRP)
PI ($16,000)
The purpose of this grant was to develop a research project to be performed at Casa Hogar del Campesino, an NGO-sponsored hospital in Cusco, Peru. Our study was undertaken to examine the prevalence and severity of alcohol use, knowledge and cultural perceptions of alcohol use and knowledge of existing educational resources among this population.

2013 PRO-M Combination Rapid Detection of Ruptured Membranes
Pro-Lab Developments, Inc.
This is a pilot study to determine the clinical performance of PROM Combo test relative to

clinical diagnosis for the detection of premature membrane rupture in a point-of-care (POC) setting.

2015 Impact of the Resident-as-Teacher Video Series in Preparing Students to be Resident Teachers
This is a survey study of fourth-year Harvard Medical Students attending a four-week Boot Camp to assess the efficacy of the Resident-as-Teacher Video Series in improving future trainees' comfort and confidence in teaching.

2015 Best Practice Curriculum for Training Residents as Teachers
This is a multi-site study to assess the current state of the Resident-as-Teacher curricula in the Harvard Medical School-affiliated residency training programs in addition to establishing a best practice checklist for Residency Program Directors in implementing training in resident teaching. We then plan to implement this checklist in Harvard Medical School affiliated training programs and use it to serve as a national model of excellence.

Report of Clinical Activities and Innovations

Current Licensure and Certification

06/12-present	Massachusetts Limited Medical License
03/15-present	Fundamentals of Laparoscopic Surgery Certification

Practice Activities

06/12-	Obstetrics and Gynecology Residency Training	Beth Israel Deaconess Medical Center	Residency Training

Report of Local Teaching and Training

Teaching of Students

2013-present	GYN 101 Lecture Third Year Harvard Medical Student Clerkship	1.0 hour
March 2014	OBGYN Boot Camp Faculty *Open Suturing Skills Session* *Constructing the Pelvis* *Laparoscopic Skills Session* Fourth Year Harvard Medical Students	4 weeks per year 3.0 hours 4.0 hours 3.0 hours
January 11, 2016	APGO Faculty Development Seminar *Constructive Dissection of the*	1.25 hours

Pelvis: A Simulation to Improve Clinical Knowledge of Gynecologic Anatomy

Professional Development Courses

May 30-June 1, 2015	2015 CREOG Resident Leadership Workshop Philadelphia, PA	12.0 hours
January 10-11, 2016	APGO Faculty Development Seminar	12.0 hours

Report of Education of Patients and Service to the Community

Activities

2005	Judeo-Christian Health Clinic/ Translator Served as a translator between English-speaking physicians and Spanish-speaking patients in a free health clinic for underserved patients in Tampa, Florida.
2006	Treatment and Education of Autistic and Communication-related Handicapped Children (TEACCH) Autism Program/ Volunteer Assisted with in-home education and therapy of young children recently diagnosed with autism.
2007-2010	International Health Outreach Trip to San Francisco, Honduras/ Participant Volunteered in a rural clinic assisting a General Medicine physician, participating in community health fairs and providing public health education.
2009	International Summer Research Program in Peru/ Participant and Research Co-coordinator Volunteered at Casa Hogar del Campesino, an NGO-sponsored hospital in Cusco, Peru.
2009-2011	Camp Boggy Creek/ Family Weekend Volunteer Volunteered at a camp for children with life-threatening illnesses.
2009-2012	Equal Access Clinic/ Volunteer Volunteered at a student-run medical clinic that serves the indigent population of Gainesville, Florida.
2009-2012	Project Yucatan International Health Outreach Trip/ Participant and Trip Leader Partnered with medical students, physicians and pharmacists to provide medical care to the underserved patients of rural Mayan villages in the Yucatan peninsula of Mexico.
2014	Hópital Albert Schweitzer/ Volunteer Physician Volunteered to provide Obstetric & Gynecologic care to women in the underserved, rural communities surrounding Deschapelles, Haiti, a region with a high maternal and perinatal mortality rate.
2014	International Health Outreach Trip to Clinica Nueva Esperanza (New Hope Clinic) in San Francisco, Honduras/Volunteer physician Volunteered to provide Obstetric & Gynecologic care to underserved women in a rural clinic in San Francisco de Orica, Honduras, including Pap screening and obstetric ultrasound.

2015 Volunteer for Clinica Nueva Esperanza, Honduras
Assisted Dr. Cesar Davila, the clinic's physician, in designing his clinic's new laboratory, as well as with with Spanish interpretation during his Continuing Medical Education (CME) experience in the US.

Report of Scholarship

Peer reviewed publications in print or other media

1. **McKeon BA**. Congenital diaphragmatic hernia. CREOG On-Line Resident Quiz Series, American College of Obstetricians and Gynecologists, 2011.

2. Clark W, Hernandez J, **McKeon B**, Villadolid D, Al-Saadi S, Mullinax J, Ross SB, Rosemurgy AS. Surgical Shunting versus Transjugular Intrahepatic Portasystemic Shunting for Bleeding Varices Resulting from Portal Hypertension and Cirrhosis: A Meta-Analysis. The American Surgeon. 2010; 76: 857-64.

3. Clark W, Hernandez J, **McKeon BA**, Kahn A, Morton C, Toomey P, Mullinax J, Ross S, Rosemurgy A. Surgery residency training programmes have greater impact on outcomes after pancreaticoduodenectomy than hospital volume or surgeon frequency. HPB: The Official Journal of the International Hepato-Pancreato-Biliary Association (Oxford). 2010; 12: 68-72.

4. March MI, Geahchan C, Wenger J, Raghuraman N, Berg A, Haddow H, **McKeon BA**, Narcisse R, D JL, Scott J, Thadhani R, Karumanchi SA, Rana S. Circulating Angiogenic Factors and the Risk of Adverse Outcomes among Haitian Women with Preeclampsia. Crispi-Brillas F, ed. *PLoS ONE*. 2015;10(5):e0126815. doi:10.1371/journal.pone.0126815.

Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings

1. Kirtane K, **McKeon B**, Davis S, Yasova LD, Rodney J, Mishra S, Casey R, Connor C, Strul S, Pasteur N. "Exploring the Prevalence and Perception of Alcoholism Among Indigenous Peruvians: 2011 Update." Medical Student Research Day, Gainesville, Florida, April 8, 2011.

2. Kirtane K, **McKeon B**, Davis S, Yasova LD, Rodney J, Mishra S, Casey R, Connor C, Strul S, Pasteur N. "Exploring the Prevalence and Perception of Alcoholism Among Indigenous Peruvians." Medical Student Research Day, Gainesville, Florida, March 29, 2010.

3. Kline A, Green E, Chakraborty A, Winter K, Saxena P, Nigella S, Milliron B, Frater F, Sims T, Prokai D, **McKeon B**, Casey R, Davis S, Connor C, Kirtane K, Mishra S, Pasteur N, Rodney J, Strul S, Yasova L, Lawrence R. "Cultural Understanding of Leishmaniasis in Cusco, Peru." Medical Student Research Day, Gainesville, Florida, March 29, 2010.

4. Zoe McKee, MD, **Bri Anne McKeon, MD**, Anna M. Modest, MPH, Michele Hacker, ScD, MSPH, Michael J. Eveleigh, Ph.D., RAC, Toni Golen, MD. "Detection of premature rupture of membranes by measuring insulin growth factor binding Protein 1 and Alpha-Fetoprotein." Women's Health Congress Scientific Poster Session, Washington, DC, April 5, 2014.

5. Zoe McKee, MD, **Bri Anne McKeon, MD**, Anna M. Modest, MPH, Michele Hacker, ScD, MSPH,

Michael J. Eveleigh, Ph.D., RAC, Toni Golen, MD. "Detection of premature rupture of membranes by measuring insulin growth factor binding Protein 1 and Alpha-Fetoprotein." BIDMC Resident Poster Presentation Competition, Boston, MA, June 2, 2014.

6. **McKeon B**, Royce C, Vicari R, Haviland MJ, Newman L, Ricciotti H. Impact of the Resident-as-Teacher Video Series in Preparing Students to be Resident Teachers. Harvard Medical School Medical Education Day, Boston, MA, October 27, 2015.

7. **McKeon B**, Royce C, Vicari R, Haviland MJ, Newman L, Ricciotti H. Impact of the Resident-as-Teacher Video Series in Preparing Students to be Resident Teachers. 2016. To be presented as a poster at the Annual Meeting of CREOG and APGO, New Orleans, LA.

PRINT NAME: BriAnne McKeon DATE: 12 15 2015

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: Bri Anne McKean DATE: 12/15/2015

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: BriAnne McKeon DATE: 12/15/2015

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: BriAnne McKeon DATE: 12/15/2015

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: BriAnne McKeon MD Date: 12/15/2015

Seal Verified
DATE: 1-25-16
INITIALS: KY

Sealed Envelope
Initials: KY

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

BRI ANNE MCKEON, MD
(name of applicant)

for 4 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of applicant

Signature of Certifying Physician

I certify that the photograph above is a genuine likeness of the maker of the signature above.

247979 — License Number
MA — State

MONICA MENDOLA, MD
Type or print name clearly

Signature of Notary

Address: 336 BROOKLINE AVE.
E/KS 3
City: BOSTON State: MA Zip: 02043

1.26.2019
My commission expires

Telephone: (617) 667-2255

Date: 01/13/16

***Instructions to the certifying physician**: Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.*

Form B

Medical School Verification Form

Applicants who are fourth year medical school students and who have co requirements for the M.D./D.O. degree, but have not yet been awarded the degree are also required to have this form completed by their medical school.

Original signature of the Dean or another medical school official is required to complete the requested information. Signature stamps will not be accepted.

Any state medical board to whom you have certified an applicant's graduation would wish to be notified immediately regarding a medical school's determination that the applicant will not graduate.

Please complete Form A and return it to the sender. This Form B must be sent to the Board of Registration in Medicine after the student completes the degree requirements.

My signature below certifies that BRI ANNE McKEON
(Student's Name)

has completed the requirements for the ☒ M.D. degree ☐ D.O. degree

from University of Florida College of Medicine
(Name of Medical School)

and will receive the degree on 05 / 19 / 2012. **Amelia Martinsen**

Signature of Certifying Official: Amelia Martinsen
(Original Signature is required – Stamps not accepted)

Printed Name: **Amelia Martinsen**

Title: **Senior Registrar Officer for Medicine**

Date: 05/11/2012

Please return the completed Form B to the Limited License Coordinator, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - Telephone: (781) 876-8210 Fax: (781) 876-8383. Thank you

Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please Note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Bri Anne McKean Date of Birth ___.___.____

Print or Type Name: McKean (Last name) Bri (First Name) A. (Middle Initial) Social Security No: _____

Other Name(s) _____ (Please type or print name(s))

Name of Medical School: University of Florida College of Medicine

Address: 1600 SW Archer Road City: Gainesville State or Province: Florida

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A and complete Form B if the above named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: The University of North Carolina at Chapel Hill

Undergraduate School Address: CB#2100 SASB North, Chapel Hill, NC, 27599-2100

Continued on page 2

LIMITED LICENSE APPLICANT – FORM A

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	McKEON (Last name)	BRI ANNE (First name)	(Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	**FROM**	**TO**	**FROM**	**TO**
	08/18/2008	06/05/2009	07/05/2011	05/11/2012
	08/17/2009	05/14/2010	/ /	/ /
	07/06/2010	06/17/2011	/ /	/ /

The applicant attended 164 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one ☐ was awarded a degree in _____ on (month/day/year) ____/____/____

☒ will be awarded on 05/19/2012 **(Form B must also be completed and returned directly to the Board)**

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	**NO**
1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

Seal Verified
DATE: 5-11-12
INITIALS: EAH

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Amelia Martinsen

Print Name: **Amelia Martinsen**

Title: **Senior Registrar Officer for Medicine**

Date: 04/04/2012 Telephone: (352) 273-7978

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Bri Anne McKeon MD

Print or Type Name: Britanne McKeon, MD Date: 12/15/2015

Name of Institution: Beth Israel Deaconess Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: BETH ISRAEL DEACONESS MEDICAL CENTER

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that BRI ANNE MCKEON, MD (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
~~PGY~~ RESIDENCY	1	GB/GYN	06.18.12	06.16.13	YES	ACGME
RESIDENCY	2	GB/GYN	06.17.13	06.20.14	YES	ACGME
RESIDENCY	3	GB/GYN	06.23.14	06.21.15	YES	ACGME
RESIDENCY	4	GB/GYN	06.22.15	06.19.16	ANTICIPATED	ACGME

MM 3.24.2016

(Continued on page 2)

APPLICANT'S NAME: Bri Anne McKeon, MD

POSTGRADUATE VERIFICATION FORM PAGE - 2

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☑ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE
(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: _____

Print Name: Monica Mendiola, MD

Academic Title: Residency Program Director

Telephone: (617) 667-2285 Today's Date: 1/13/15

E-mail address: mmendiol@bidmc.harvard.edu

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 1-25-16
INITIALS: KY