

MA License Number: 214041
Date license revived: 1/1/

Image
1 04/15/10

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

REDACTED COPY

LAPSED LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of \$700.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

JAN 25 2010

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

Bryant Mantha Allison Sarah
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Medical Degree: M.D. D.O. Ph.D. Other degree M.P.H.

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

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

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

Place of Birth: New York NY
City State/Province/Territory Country if not USA

Home Address: _____
Number and Street
City State/Province/Territory Zip (or postal) Code

Business Address: 505 Parnassus Avenue, Box 0137
Number and Street
San Francisco CA 94143
City State/Province/Territory Zip (or postal) Code

Business Telephone: (415) 476-3910 ext. _____ Home Telephone: _____

E-mail Address _____ Fax Number: (415) 476-1811

Preferred Mailing Address: Business Address Home Address

APPLICANT'S NAME: Allison Bryant Mantha

Postgraduate Education:

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility:	Position:	From	To
<u>Mass. General/Brigham+Women's</u> Street: <u>75 Francis Street</u>	<u>Resident</u> City: <u>Boston</u>	<u>6/20/1998</u>	<u>6/20/2002</u> State: <u>MA</u>
<u>Brigham+Women's Hospital</u> Street: <u>75 Francis Street</u>	<u>Fellow</u> City: <u>Boston</u>	<u>7/1/2002</u>	<u>6/30/2005</u> State: <u>MA</u>
<u>Commonwealth Fund/Harvard</u> Street: <u>164 Barnard Ave. BOST</u>	<u>Fellow</u> City: <u>Boston</u>	<u>7/1/2003</u>	<u>6/30/2004</u> State: <u>MA</u>
<u>UCSF, Advanced Training Clin. Res.</u> Street: <u>185 Berry Street</u>	<u>Fellow</u> City: <u>San Francisco</u>	<u>8/1/2005</u>	<u>6/30/2006</u> State: <u>CA</u>
Facility: _____ Street: _____	Position: _____ City: _____	_____/_____/_____/_____/_____/_____	_____/_____/_____/_____/_____/_____

Hospital Affiliations and Employment

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

Facility:	Position:	From:	To:
<u>Brigham+Women's Hospital</u> Street: <u>75 Francis Street</u>	<u>Generalist</u> City: <u>Boston</u>	<u>7/20/2002</u>	<u>6/30/2005</u> State: <u>MA</u>
<u>Planned Parenthood League of MA</u> Street: <u>1055 Commonwealth Avenue</u>	<u>Staff MD</u> City: <u>Boston</u>	<u>12/1/2002</u>	<u>6/30/2005</u> State: <u>MA</u>
<u>UCSF Medical Center</u> Street: <u>505 Parnassus Avenue</u>	<u>Asst. Professor</u> City: <u>San Francisco</u>	<u>8/1/2005</u>	<u>present</u> State: <u>CA</u>
<u>San Francisco General Hospital</u> Street: <u>1001 Potrero Avenue</u>	<u>Asst. Professor</u> City: _____	<u>7/1/2006</u>	<u>present</u> State: _____
<u>Valley Care Medical Center</u> Street: <u>5565 Las Positas Drive</u>	<u>Attending Physician</u> City: <u>Pleasanton</u>	<u>7/1/2009</u>	<u>present</u> State: <u>CA</u>
Facility: _____ Street: _____	Position: _____ City: _____	_____/_____/_____/_____/_____/_____	_____/_____/_____/_____/_____/_____

through June 2010

APPLICANT'S NAME: Allison Bryant Mantha

Medical Malpractice Information:

My medical malpractice insurance coverage is by: Insurance carrier Letter of Credit

Print name of insurer: UC Regents Self-Insured Program

Policy dates: From: August 2005 To: ~~present~~ June 30, 2010

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

I am not involved in direct patient care Otherwise exempt

Explain exemption _____

Continuing Medical Education Credits

Read instructions for continuing medical education requirements before completing.

Activity status: Active Exemption _____

Category 1 credits 110
Category 2 credits 200

Risk Management Category 1 5
Risk Management Category 2 8

Continuing medical education credit requirements must be completed before the lapsed license can be revived if you are applying for active license status. (See Lapsed License Instructions).

1. List other states (abbreviations) where you are currently or have ever been licensed: CA _____

2. Are you certified by the American Board of Medical Specialties (ABMS)? Yes No

3. List only ABMS certification(s): Obstetrics and Gynecology, Maternal and Fetal Medicine

4. Reason for requesting revival of lapsed license in Massachusetts: I am returning to live and work in Massachusetts

5. Please attach your current curriculum vitae

NATIONAL PROVIDER IDENTIFIER (NPI)

Image 4 04/15/10

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers were required to obtain an NPI by May 23, 2007.

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

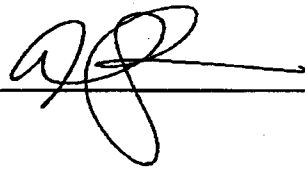
My current NPI is:

1	3	8	6	6	8	4	9	2	6
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Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

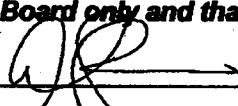
Please sign and date to confirm that all of the information on this form is true and accurate.

Signature:  Date: 1 / 15 / 10

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under the pains and penalties of perjury, I declare that I have examined this Lapsed License Application and all of its accompanying instructions, forms and statements, and, to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for revival of a lapsed license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature:  Date: 1/15/10

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Revised: 10.05.09

APPLICANT'S NAME: Allison Bryant Mantha

Postgraduate Education:

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: <u>Mass. General Brigham+Women's</u>	Position: <u>Resident</u>	<u>From</u>	<u>To</u>
Street: <u>75 Francis Street</u>	City: <u>Boston</u>	<u>6/20/1998</u>	<u>6/20/2002</u>
State: <u>MA</u>			
Facility: <u>Brigham+Women's Hospital</u>	Position: <u>Fellow</u>	<u>7/1/2002</u>	<u>6/30/2005</u>
Street: <u>75 Francis Street</u>	City: <u>Boston</u>		
State: <u>MA</u>			
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____		
State: _____			
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____		
State: _____			
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____		
State: _____			

Hospital Affiliations and Employment

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

		<u>From:</u>	<u>To:</u>
Facility: <u>Brigham+Women's Hospital</u>	Position: <u>Generalist</u>	<u>7/1/2002</u>	<u>6/30/2005</u>
Street: <u>75 Francis Street</u>	City: <u>Boston</u>		
State: <u>MA</u>			
Facility: <u>Planned Parenthood League of MA</u>	Position: <u>Staff MD</u>	<u>12/1/2002</u>	<u>6/30/2005</u>
Street: <u>1055 Commonwealth Avenue</u>	City: <u>Boston</u>		
State: <u>MA</u>			
Facility: <u>UCSF Medical Center</u>	Position: <u>Asst. Professor</u>	<u>8/1/2005</u>	<u>present</u>
Street: <u>505 Parnassus Avenue</u>	City: <u>San Francisco</u>		
State: <u>CA</u>			
Facility: <u>San Francisco General Hospital</u>	Position: <u>Asst. Professor</u>	<u>7/1/2008</u>	<u>present</u>
Street: <u>1001 Potrero Avenue</u>	City: _____		
State: _____			
Facility: <u>Valley Care Medical Center</u>	Position: <u>Attending Physician</u>	<u>1/2008</u>	<u>present</u>
Street: <u>5565 Las Positas Drive</u>	City: <u>Pleasanton</u>		
State: <u>CA</u>			
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____		
State: _____			



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Allison S Bryant Mantha, M.D.

License No.: 214041

Current Status: Active

License Expiration Date: 12/9/2010

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 55 Fruit Street
Founders 4/ Mass. General Hospital
Boston
Massachusetts - 02114
United States of America
(617) 724-0138

3) Email Address:

4) Fax Number: (617) 726-4267

5) Specialties
Maternal and Fetal Medicine
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
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8) Other states where you are now licensed to practice
California

9) States where you were previously licensed
None Reported

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Massachusetts General Hospital	



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Allison S Bryant Mantha, M.D.

License No.: 214041

11) Care of patients in Massachusetts

Average weekly hours involved in:
a) inpatient care 10 hrs/wk
b) outpatient care 15 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2010	06/30/2011	Claims made with tail coverage

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
- b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
- b) Have any criminal offenses/charges against you been resolved during this time period?
- c) Are there any criminal charges pending against you today?
- d) Are any Application of Issuance of Process pending against you?

18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
- b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
- c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
- d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Allison S Bryant Mantha, M.D.

License No.: 214041

- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)**
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Allison S Bryant Mantha, M.D.

License No.: 214041

Compliance with Legal Responsibilities

Online profile:

I have reviewed my Physician Profile and confirm that the information is accurate.

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.

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