Application # 98 - 7144 - 02

Date of Issue: 5/20/98

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111

REDACTED COPY

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

- ☒ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- ☐ Graduate of an International Medical School (IMG)
- ☐ Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) Bryant (First) Allison (MI) S

1-B. Other Name(s): _____

	YES	NO
1) Have you ever been known under a different name or combination of names?	☐	☒
2) Have you ever been licensed under a different name?	☐	☒
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☒

If yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

3. Date of Birth ____ ____ ____ (Month Day Year) Place of Birth: New York City

4. Sex: ☐ Male ☒ Female 5. Social Security Number: _____

6. Name of Massachusetts Training Hospital: Brigham and Women's Hospital

75 Francis Street (Street Address) Boston (City)

DATE: 4/28/98
INITIAL: [illegible]
FEE: $50.00 Check

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APR 28 1998
BOARD OF REGISTRATION IN MEDICINE

7. Name of premedical school(s): Harvard College

Location: ~~Cambridge~~ Boston, MA, USA
(City, State, Country)

8. Name of medical school(s): Harvard Medical School

Location: Boston, MA, USA
(City, State, Country)

Year of Graduation: 1998 Degree Received: ☒ M. D. ☐ D. O. Other(specify)_____

9. Have you had previous post-graduate training? ☒ No ☐ Yes ☐ U.S. or ☐ International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you are currently licensed to practice medicine:

_____ _____ _____ _____ _____

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):

_____ _____ _____ _____ _____

12. Medical School Training:

	YES	NO
a) If you are a USMG, have you taken more than 4 years to complete medical school?	☐	☒
b) If you are an IMG, have you taken more than 6 years to complete medical school?	☐	☐

If yes, you must provide additional information. (See instructions.)

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? ☐ ☒
If yes, you must provide additional information. (See instructions.)

NAME: Allison S. Bryant

	YES	NO
14. Have you ever been enrolled in a residency training program(s) that you did not complete? **If yes, a letter from your program director is required.** (See instructions.)	☐	☒

Explanation attached?_____ Program Director's Certification requested? _____

SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.

	YES	NO
15. Since your matriculation in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program?		
17. Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		

		YES	NO
21.	Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
22.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you ever voluntarily relinquished medical staff membership?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?		
26.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to 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?		
28.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

NAME: Allison S. Bryant

SECTION C: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Allison S. Bryant has been appointed
(Name of Applicant)

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the Ob/Gyn
(Name of Program)

at BRIGHAM & WOMEN'S HOSPITAL
(Name of Hospital)

beginning 6 / 20 / 98 to anticipated completion of training: 6 / 30 / 02
month day year month day year

	YES	NO
Is the program accredited by the ACGME?	☒	☐
If **no**, is there an ACGME-approved training program in the applicant's specialty?	☐	☐

Designated Official's Signature: Shawn M Vanner

Type or Print Name: Shawn Vanner, Manager
Graduate Medical Education

Official Title:

Date: 4 / 23 / 98 Telephone Number: 617-732-8540

4/22
INITIAL LLS
FEE $50.00 Check 271

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APR 22 1999
Board of Registration in Medicine

Application #: 98-7144-02
Date Approved: 4/29/1999

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS A AND C ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

Section A:

1. Name: (Last) Bryant (First) Allison (MI) S
2. Mailing Address: _____ Telephone Number: _____
   City, State and Zip: _____
3. Name of Training Hospital: Brigham and Women's Hospital
4. Current Limited License Number: 98-7144-02
5. Other states (abbreviations) where you are now fully licensed to practice medicine: _____ _____ _____

Section B: To be completed by program director.

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Robert L. Barbieri M.D. Date: 4/12/99

Signature of Program Director: Robert Barbieri Telephone (617)732-5444

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Allison Bryant (Name of Applicant) has been appointed to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY _____

Program Name: OB/GYN Facility: BRIGHAM & WOMEN'S HOSPITAL

Beginning Date: 6/20/98 Anticipated Completion Date of Training: 6/30/02

Is the program accredited by the ACGME: ☒ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Shawn Vanner, Manager Graduate Medical Education Telephone: 617-732-8540
(Print Name) (Title)

Designated Official's Signature: Shawn M Vanner Date: 4/16/99

NAME:_____

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

		YES	NO
SINCE YOUR LAST RENEWAL			
16.	Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?		
17.	Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18.	Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19.	Have you voluntarily surrendered a license to practice medicine or any healing art?		
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21.	Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).		
22.	Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you voluntarily relinquished medical staff membership?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?		
26.	Have you been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29.	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Pd 3/31/00 $50 CK 3654 pc

Application #: 7144
Date Approved: 3/31/00

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RECEIVED MAR 14 2000 BOARD OF REGISTRATION IN MEDICINE

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS "A"AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

1. Name: (Last) BRYANT (First) ALLISON (MI) S
2. Mailing Address: _____ Telephone Number: _____
   City: _____ State: _____ Zip: _____
3. Name of Training Hospital: BRIGHAM&WOMEN'S / MASS. GENERAL HOSPITALS
4. Current Limited License Number: 98-7144-02
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

SECTION B: To be completed by program director.

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Robert L. Barbieri, M.D. Date: 3/8/2000

Signature of Program Director: Robert L Barbieri Telephone: 617.732.5444

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Allison Bryant (Name of Applicant) has been appointed

to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY _____

Hospital Name: BRIGHAM & WOMEN'S HOSPITAL Specialty: OB/GYN

Beginning Date: 6/20/98 Anticipated Completion Date of Training: 6/30/02

Is the program accredited by the ACGME: ☒ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Shawn Vanner, Manager Graduate Medical Education (Print Name) (Title) Telephone: 617-732-8540

Designated Official's Signature: Shawn M Vanner Date: 3/10/00

NAME: ALLISON S. BRYANT

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

YES NO

SINCE YOUR LAST RENEWAL

Note: These questions apply only since your last renewal.

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?

19. Have you voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?

26. Have you been charged with any criminal offense, other than a minor traffic offense?

27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?

28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

3/13/01
INITIAL: BF CK
FEE: $50.00 CHECK CK# 474

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MAR - 9 2001
BOARD OF REGISTRATION IN MEDICINE

Application #: 7144
Date Approved: 3/13/01

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, Third Floor, Boston, Massachusetts 02111 - www.massmedboard.org

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

1. Name: (Last) BRYANT (First) ALLISON (MI) S
2. Mailing Address: _____ Telephone Number: _____
   City: _____ State: _____ Zip: _____
3. Name of Training Hospital: BRIGHAM AND WOMEN'S HOSPITAL/MGH
4. Current Limited License Number: 98-7144-02
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). _____ ☐(F) ☐(L) _____ ☐(F) ☐(L) _____ ☐(F) ☐(L)

SECTION B: To be completed by program director.

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Robert L. Barbieri, M.D. Date: 3/1/01

Signature of Program Director: Robert L. Barbieri Telephone: 617-732-4265

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Allison Bryant, M.D. (Name of Applicant) has been appointed

to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY_____

Hospital Name: Brigham and Women's Hospital Specialty: OB/GYN

Beginning Date: 6/20/98 Anticipated Completion Date of Training: 6/30/02

Is the program accredited by the ACGME: ☒ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Mary Albertini, Physician Services Telephone: 617-732-9436
(Print Name) (Title)

Designated Official's Signature: Mary Albertini Date: 3/8/01

NAME: Allison Bryant

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

THESE QUESTIONS APPLY ONLY SINCE YOUR LAST RENEWAL	YES	NO
16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?		
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19. Have you voluntarily surrendered a license to practice medicine or any healing art?		
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).		
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?		
24. Have you voluntarily relinquished medical staff membership?		
25. Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?		
26. Have you been charged with any criminal offense, other than a minor traffic offense?		
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

SUPPLEMENT FORM

PRINT NAME: Allison S. Bryant DATE: 2/23/02

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the *additional information on pages 4-10.*

		YES	NO
1.	Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2.	Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
3.	Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5.	Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?		
6-A.	Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7.	Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards?		
8-A.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

PRINT NAME: Alison S. Bryant

YES NO

9-A. Have you ever voluntarily relinquished any medical staff membership?

9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital 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 or governing board?

9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

10. Have you ever been charged with any criminal offense, other than a minor traffic offense?

11. Has your privilege to 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 related to professional competency or conduct 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 been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?

14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature: Alison S. Bryant **Date:** 2/23/02

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MAR 25 2002
BOARD OF REGISTRATION IN MEDICINE

Application #: 214041
Date of Issue: _____

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor
Boston, MA 02111 - (617) 727-3086

#594
Glenn
3/26/02

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

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

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

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

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____

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.)

Date of Birth: ___/___/___ (Month Day Year) Social Security Number: _____ _____

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: 75 Francis Street
Number and Street

Boston | MA | 02115
City | State/Province/Territory | Zip (or postal) Code

Business Telephone: (617) 7326660, ext. 30069 Home Telephone: (_____

Preferred Mailing Address: ☒ Business Address ☐ Home Address

PRINT NAME: Allison Bryant PAGE 2 OF 3

Pre-medical School

				From	To
Facility: Harvard College	Degree: AB			9/ 90	6/ 94
Street:	City: Cambridge		State: MA		
Facility:	Degree:			/ /	/ /
Street:	City:		State:		

Medical School

				From	To
Facility: Harvard Medical School	Degree: MD			9/ 94	6/ 98
Street:	City: Boston		State: MA		
Facility:	Degree:			/ /	/ /
Street:	City:		State:		

Date of medical school graduation: June 98

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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.

				From	To
Facility: Brigham & Women's Hospital	Position: PGY 1→4			7/20/98	6/22/02
Street: 75 Francis St.	City: Boston		State: MA		
Facility:	Position:			/ /	/ /
Street:	City:		State:		
Facility:	Position:			/ /	/ /
Street:	City:		State:		
Facility:	Position:			/ /	/ /
Street:	City:		State:		
Facility:	Position:			/ /	/ /
Street:	City:		State:		

PRINT NAME: Allison S. Bryant PAGE 3 OF 3

Hospital Affiliations and Employment

List 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, in chronological order. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: Groote Schuur Hospital	Position: Registrar	5/12/01	6/10/02
Street:	City: Capetown		State: South Africa
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 been licensed: ___ ___ ___
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): _____
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Clinical Fellowship
6. Name of Facility: Brigham & Women's Hospital
7. Address: 75 Francis Street City: Boston
8. Anticipated starting date in Massachusetts: 7/01/02

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

Signature of Applicant Date 2/23/02

Rev: 12/24/2001