CR # 10823749

Application #: 252584



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

# INITIAL LIMITED LICENSE APPLICATION

**IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $100.00 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)

**NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS**

**SECTION A: Sworn Statement To Be Completed by Applicant**

1-A. Name: (Last) Brant (First) Ashley (MI) R

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

2. Current Address: [redacted] Telephone Number: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]

3. Date of Birth: [redacted] (Month Day Year) Place of Birth: [redacted]
E-mail Address [redacted]

4. Sex: ☐ Male ☒ Female 5. Social Security Number: [redacted]

6. Name of Massachusetts Training Program: Baystate Medical Center
Dept. of ob/Gyn
759 Chestnut St. Springfield
Street Address (City)

Date Received: 5/4/12

Check #: 10823749

Check Amount: $ 22

Initials: _____

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE TEACHING PROGRAM AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT**

This certifies that Ashley R. Brant (Name of Applicant) has been appointed

to the position of ☒ Intern ☐ Resident ☐ Fellow

in the specialty of Obstetrics & Gynecology as a PGY 1

Department: Obstetrics & Gynecology Subspeciality: _____

at Baystate Medical Center (Name of Healthcare Facility)

beginning 07 / 01 / 2012 (Month) (Day) (Year) to anticipated completion of training: 07 / 01 / 2016 (Month) (Day) (Year)

| | YES | NO |
|---|---|---|
| 1. Is the program accredited by the ACGME? | ☒ | ☐ |
| 2. If **no**, is there an ACGME-approved training program in the applicant's specialty ? | ☐ | ☐ |
| 3. Have you reviewed Sections A and C of the limited license application? | ☑ | ☐ |

Designated Official's Signature: Paula S. Wayne

Type or Print Name: PAULA S. WAYNE

Official Title: Registrar

Date: 5 / 3 / 2012 Telephone Number: 413 794 0884

**SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT**

**PRINT NAME** Ashley Brant

7. Name of premedical school(s): Michigan State University
Location: East Lansing, MI, U.S.
(City, State, Country)

8. Name of medical school(s): Michigan State University College of Osteo. Medicine
Location: East Lansing, MI, U.S.
(City, State, Country)

Date of Graduation: 05 /04 /12 Degree: ☐ M. D. ☒ D. O. Other (specify)_____
(Month) (Day) (Year)

(See Limited Instructions, (page 3), for completing Medical Education forms for fourth year medical school students.)

9. Have you had previous postgraduate training in the United States? ☒ No ☐ Yes
Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/____ Specialty: _____

Name of Postgraduate Training Program _____
City: _____ State: _____
Training Dates: From: __/__/____ To: __/__/____ Specialty: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *ever* had a license to practice medicine (include residency training licenses).
_____ ☐ (Full) _____ ☐ (Full) _____ ☐ (Full ) _____ ☐ (Limited) _____ ☐ (Limited)

11. Please indicate **all** the licensing examinations that you have have completed with a passing score:

USMLE ☐ Step 1 ☒ Step 2 (CK) ☐ Step 2 (CS) ☐ Step 3

NBME ☐ Part 1 ☐ Part II ☐ Part III ☒ COMLEX ☒ Level 1 ☒ Level 2 ☐ LMCC

| | YES | NO |
|---|---|---|
| 12-A. If you are a USMG, have you taken more than 4 years to complete medical school? | | [redacted] |
| 12-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 with your curriculum vitae and include the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.) | | |

**COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE**
**200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880**

# AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Ashley Renée Brant
(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 Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard 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.

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.

Ashley Brant
Applicant's Signature

3/21/12
Date of Signature

Brant, Ashley R.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

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

# DOCUMENTS RECEIVED FROM DESIGNATED OFFICIAL

This is to confirm that

Physician's Name: Ashley (First Name) R. (Middle Name) Brant (Last Name)

is applying for a limited license in Massachusetts. I received and opened the documents listed below that were sent to me by the physician in sealed envelopes or directly from the primary source:

- ☑ Medical school verification form
- ☑ Medical School transcripts
- ☐ Letter from program director
- ☐ Evaluations
- ☐ Leave of absence
- ☑ Other documents (describe): Letter of good standing

I hereby certify under the penalties of perjury that I have not altered the attached documents and they are forwarded to the Board of Registration in Medicine, with the original envelopes attached, as received by me.

Designated Official: Paula S. Wayne Date: 5.3.2012

Title: Registrar

Name of Institution: Baystate Medical Center

**NOTE: Malpractice complaints, dismissals and other legal documents must be sent directly to the Board of Registration in Medicine from the primary source.**

*Affix* institutional seal or if the institution does not have a seal, this form must be notarized.

Zip/Limitedreleast/2

Seal written 5/2/12 SM

06/27/12 $20

# Ashley R. Brant, MPH

## EDUCATION:

6/2008 - 5/2012 **Michigan State University College of Osteopathic Medicine**, East Lansing, MI
*Doctor of Osteopathic Medicine degree expected 5/3/2012*

8/2005- 5/2007 **University of Michigan School of Public Health**, Ann Arbor, MI
Master of Public Health, Health Behavior and Health Education
Reproductive and Women's Health Interdepartmental Concentration

8/2000- 5/2004 **Michigan State University,** East Lansing, MI
*Bachelor of Science in Human Biology*, College of Natural Science

## RESEARCH EXPERIENCE:

9/2006 – 8/2008 **Special Moms Special Babies of the Michigan Family Study**
**Research Associate**
- Managed recruitment of research participants at a university affiliated health center for an intervention study aimed at promoting infant mental health
- Trained students to perform duties related to recruitment, home visiting, and data management
- Conducted home visits with participants to administer semi-structured surveys and performed HOME assessments
- Conducted phone interviews with control group participants

7/2004 - 7/2005 **CDC, NCHSTP, Division of HIV and AIDS Prevention**
**Oak Ridge Institute for Science and Education Fellow**
- Developed Real-Time PCR assays to detect HIV mutations associated with drug resistance
- Participated in Surveillance of Drug Resistance Working Group

5/2003 - 8/2003 **University of Toledo (formerly the Medical College of Ohio), Graduate School**
**Summer Undergraduate Research Fellow**
- Designed and executed a research project under the supervision of faculty and graduate students
- Performed extensive protein work using Immunoprecipitation, SDS-PAGE, Western blotting, and various gel staining techniques
- Presented research findings to faculty and program participants

1/2003 - 5/2003 **Molecular Reproductive Endocrinology Lab, Michigan State University**
**Lab Aide**
- Purified antibodies from bovine serum
- Organized and modified protocols, lab maintenance

5/2002 - 8/2002 **Division of Pulmonary and Critical Care Medicine, University of Michigan**
**Research Assistant**
- Stained tissue slides for the detection of antibodies
- Assisted with all lab procedures; tissue culture, plasmid purification, and ELISA

## PROFESSIONAL EXPERIENCE:

9/2009 – 5/2010 **Scribe Service, Michigan State University College of Osteopathic Medicine**
**Professional Note Taker**
- Assembled comprehensive notes from course-packs, lectures, and online material
- Organized and presented notes in an outline format
- Audited notes created by other students to correct mistakes, add images/diagrams, and add emphasis to important information

4/2007 - 7/2008 **Doulas Care, Center for the Childbearing Year**
**Volunteer Birth Doula for Low-Income Families**
- Met with clients three times during their pregnancy to discuss the birth plan, nutrition, infant care, and other health education needs
- Provided continuous support during labor, birth, and immediately postpartum
- Met with clients three times during the postpartum period to discuss breastfeeding, maternal infant bonding, adjustment, depression assessment, and resource referral.
- Provided extended postpartum services when additional support was needed

8/2006 – 4/2007 **Health Promotion and Community Relations, University Healthy Services, U of M**
**HIV Test Counselor, Volunteer**
- Counseled and tested individuals for HIV
- Conducted outreach testing at Trotter Multicultural Center at the University of Michigan
- Completed *MDCH Prevention Specialist and Test* Counselor Certifications

5/2006- 8/2006 **Title X Intern and California Family HealthCorps Volunteer**
**Los Angeles Free Clinic - Beverly, Hollywood, and Melrose sites**
- Designed and executed a family planning training needs assessment for medical assistants
- Developed an implementation plan to address training needs
- Reorganized family planning patient education materials and examined their utilization

8/2005- 4/2007 **Safe House Center**
**Response Team and Administrative Work-Study**
- Coordinated with law enforcement and sexual assault nurse examiners to identify survivors
- Provided advocacy for survivors of intimate partner violence and sexual assault
- Planned Washtenaw County Sexual Assault Awareness Month activities

5/2001- 8/2001 **Towne Centre Veterinary Associates**
**Veterinary Assistant**
- Assisted during surgery and appointments
- Routine distribution of medications, animal care and maintenance

5/1999- 8/2003 **Michigan Association of Secondary School Principals, Summer Leadership Camp**
**Head Junior Counselor** (2003)
- Managed and supervised 22 staff members
- Instructed high school students in leadership development

## PUBLICATIONS:

Johnson JA, Li J-F, Wei X, Lipscomb J, Bennett D, **Brant A**, Cong M, Spira T, Shafer R, Heneine W. (2007) Simple PCR Assays Improve the Sensitivity of HIV-1 Subtype B Drug Resistance Testing and Allow Linking of Resistance Mutations. *Public Library of Science ONE*; 5; 2(7):e638.
(Nominated for the Charles C. Shepard Science Award – Laboratory and Methods)

White ES, Flaherty KR, Carskadon S, **Brant A**, Iannettoni MD, Yee J, Orringer MB, Arenberg DA. (2003) Macrophage Migration Inhibitory Factor and CXC Chemokine Expression in Non-Small Cell Lung Cancer: Role in Angiogenesis and Prognosis. *Clinical Cancer Research*; Vol. 9, 853-860.

## HONORS / AWARDS:

| | |
|---|---|
| 2011 | **Recipient of the Riverside Osteopathic Hospital Guild Scholarship** |
| 2010 | **Recipient of the Walter J. Laird Memorial Endowed Scholarship** |
| 2009 | **Recipient of the McGraw-Hill Companies Medical Publishing 2009 Lange Student Award** |
| 2009 – Present | **Sigma Sigma Phi** |
| Spring 2004 | **Dean's Honor List,** Michigan State University |
| Fall 2003 | **Dean's Honor List,** Michigan State University |

## EXTRACURRICULAR / VOLUNTEER ACTIVITIES:

| | |
|---|---|
| 2009 – Present | **Sigma Sigma Phi**, Honorary Osteopathic service fraternity, Outreach Chair from 2009 – 2010 |
| 2008 – Present | **Planned Parenthood**, Volunteer |
| 2008 – 2010 | ***Obstetrics and Gynecology Interest Group* of MSU COM**, Secretary from 2009-2010 |
| 2008 – 2010 | **Medical Students for Choice**, President from 2009-2010 |
| 2008 – 2010 | **Lansing Area Humane Society**, Volunteer |
| 2008 – 2010 | **Community Integrative Medicine**, Member/volunteer |
| 2007 – 2009 | **Doulas of North America**, Member |
| 2006 – 2008 | **National Family Planning and Reproductive Health Association,** Member |
| 2006 – 2007 | ***Health Behavior and Health Education Student* Association,** Secretary |
| Inducted 2004 | **Alpha Epsilon Delta,** Pre-Medical Honor Society, MI Gamma Chapter |
| Inducted 2003 | **Pre-Professional Society of Alpha Epsilon Delta,** Michigan State University |
| Inducted 2003 | **Order of Omega,** Greek Honor Society |

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 ur university of graduation for verification. **Please Note: Fourth year medical students must include the letter to the m 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 yo

Applicant's Signature: _____ Date of Birt

Print or Type Name: Brant (Last name) Ashley (First Name) R. (Middle Initial) Social Security

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

Name of Medical School: MSU College of Osteopathic Medicine

Address: 965 Fee Rd., Rm C-110 City: East Lansing State or Province: M

**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 in transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return 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:
n/a

**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: _____

Undergraduate School Address: _____

Continued on page 2

**Enrollment and Participation:** Our records indicate that

Brant, Ashley R.

(type or print the applicant's name): (Last name) (First name)

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

| ATTENDANCE DATES: | FROM | TO | FROM | |
|---|---|---|---|---|
| | 06/23/08 | 08/19/09 | 08/29/11 | 05 |
| | 08/31/09 | 08/19/10 | / / | |
| | 08/30/10 | 08/18/11 | / / | |

**The applicant attended _____total weeks (must be included) of continuing on-campus education, not less than 32 weeks in**

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

☒ will be awarded on 05/04/12 **(Form B must also be completed and returned**

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

| | YES |
|---|---|
| 1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".) | [redacted] |
| 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: 5/21/12

INITIALS: LMF

**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: Kelly E. Fenn

Print Name: Kelly E. Fenn

Title: Assistant Registrar

Date: 04/24/12 Telephone: (517) 88

**This form will not be accepted unless it is stamped with the institutional seal or nota**

**PRINT NAME:** Ashley Brant 

**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 the Limited License Supplement. You must answer all questions or your application will be returned to you.**

| | YES | NO |
|---|---|---|
| 14. Have you ever been enrolled in a postgraduate training program where you were required to repeat a year of training? | | [redacted] |
| **If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.** | | |
| 15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution? | | |
| 16-A. Have you ever been terminated or granted a leave of absence, regardless of the reason, by a medical school or any postgraduate training program? | | |
| 16-B. Have you ever voluntarily left, transferred or withdrawn from a medical school or any postgraduate training program? | | |
| 16-C. Have you ever, for any reason, been placed on probation in medical school or any postgraduate training program? | | |
| **If you answered "yes" to 16-A, B or C, you must provide an explanation and request a letter of explanation from your medical school or postgraduate training program.** | | |
| 17. Since your enrollment 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? | | |

**PRINT NAME:** Ashley Brant



| | | YES | NO |
|---|---|---|---|
| 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). | | [redacted] |
| 21. | Has any disciplinary action ever 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 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 any medical staff membership, medical staff privileges or medical staff status? | | |
| 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 or has such a suit been settled, adjudicated or otherwise resolved? | | |
| 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? | | |

**PRINT NAME:** Ashley Brant



**CONFIDENTIAL MEDICAL INFORMATION**

**Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. 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 have an impact on one's functioning as a licensee, or within the past two years.**

| | | YES | NO |
|---|---|---|---|
| 30. | Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or function as a physician? | | [redacted] |
| 31. | Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician? | | |
| 32. | Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired? | | |
| 33. | Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? | | |
| 34. | Are you currently engaged in the illegal use of drugs or misuse of prescription drugs? | | |
| 35. | Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? | | |

**If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.**

## CERTIFICATIONS:

- 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 and that I have complied with all laws of the Commonwealth related to withholding and remitting child support. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §51A.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- Under the penalties of perjury, I declare that I have examined this limited license 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. As an applicant for a limited 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.

**Applicant's Signature:** Ashley Brant **Date:** 3/21/12

Revised: 11.30.10

**Commonwealth of Massachusetts**
**Board of Registration in Medicine**
**200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**
**Telephone (781) 876-8230**
**www.mass.gov/massmedboard**



## WAIVER FOR RELEASE OF INFORMATION

Completion of this waiver will authorize the release of information from the Board of Registration files to the entity listed below. This waiver form must be properly executed and no other waiver form is acceptable.

Information released pursuant to this waiver is based entirely on review of open and closed complaint files and does not include information in the license application, renewal application, or any documentation that the Board of Registration is required to obtain by statute, e.g. court documents, insurance verifications, and information from health care entities.

***"I hereby authorize and direct the Massachusetts Board of Registration in Medicine to release any and all information it may have in its possession or control, including but not limited to the substance of any complaints or communication it may have received and the action or actions it may have taken in response, to the entity named* below:"**

*(Please type or print clearly.)*

SEND LICENSE VERIFICATION TO: MD Board of Physicians

ADDRESS: 4201 Patterson Ave, PO Box 2571

CITY: Baltimore, STATE: MD ZIP: 21215-0095

PHYSICIAN'S NAME: Ashley R. Brant

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MASSACHUSETTS LICENSE NUMBER: 252584

SIGNATURE OF PHYSICIAN: AshleyRBrant

***Signed under the penalties of perjury.***

DATE: 8/16/16

Date Received: 8/26/16

Check #: 1151

Check Amount: $ 10.00

Initials: AF

***This release shall remain valid for one (1) year from the date of execution.***

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Baystate Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? ____

Has the physician been subject to past or pending disciplinary action in this Program? ____

**Name:** _____ **Date:** _____
**Designation:** _____ **Telephone:** _____

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

**Designated Official's Name:** _____ **Date:** _____
**Designated Official's Title:** _____ **Telephone:** _____

**6-A.** Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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? [redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

**14.** Have you voluntarily relinquished medical staff membership?

**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is 'yes', describe the specifics of your condition and any related treatment, including dates and diagnoses.

**21.** Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemicalsubstances, describe the specifics of the treatment, including dates and diagnoses.

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

[redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Bay State Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? ____

Has the physician been subject to past or pending disciplinary action in this Program? ____

**Name:** _____ **Date:** _____
**Designation:** _____ **Telephone:** _____

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

**Designated Official's Name:** _____ **Date:** _____
**Designated Official's Title:** _____ **Telephone:** _____

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

**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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?

[redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

**14.** Have you voluntarily relinquished medical staff membership?

**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

**21.** Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

**22.** Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

**23.** Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

**24.** Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

**25.** Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? [redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **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.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Bay State Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? ____

Has the physician been subject to past or pending disciplinary action in this Program? ____

**Name:** _____ **Date:** _____
**Designation:** _____ **Telephone:** _____

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that _____ has been appointed as _____

Department of _____

Is the program accredited by the ACGME: ____

**Designated Official's Name:** _____ **Date:** _____
**Designated Official's Title:** _____ **Telephone:** _____

**6-A.** Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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? [redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

**14.** Have you voluntarily relinquished medical staff membership?

**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

**21.** Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

**22.** Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

**23.** Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

**24.** Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

**25.** Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? [redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **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.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Bay State Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? [redacted]

Has the physician been subject to past or pending disciplinary action in this Program?

**Name:** Heather Sankey **Date:** 1/29/2013
**Designation:** OB/GYN, Program Director **Telephone:** (413) 794-5321

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that **Ashley R Brant** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

**Designated Official's Name:** Martha Anderson **Date:** 1/31/2013
**Designated Official's Title:** Program Analyst, GME **Telephone:** (413) 794-8490

**6-A.** Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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? [redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

**14.** Have you voluntarily relinquished medical staff membership?

**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

**21.** Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

**22.** Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

**23.** Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

**24.** Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

**25.** Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? [redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **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.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Baystate Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? [redacted]

Has the physician been subject to past or pending disciplinary action in this Program?

**Name:** Heather Sankey **Date:** 1/26/2015
**Designation:** OB/GYN, Program Director **Telephone:** (413) 794-5321

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that **Ashley R Brant** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

**Designated Official's Name:** Martha Anderson **Date:** 2/3/2015
**Designated Official's Title:** Program Analyst, GME **Telephone:** (413) 794-8490

**6-A.** Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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? [redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

**14.** Have you voluntarily relinquished medical staff membership?

**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is 'yes', describe the specifics of your condition and any related treatment, including dates and diagnoses.

**21.** Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemicalsubstances, describe the specifics of the treatment, including dates and diagnoses.

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

[redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:** Baystate Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? [redacted]

Has the physician been subject to past or pending disciplinary action in this Program?

**Name:** Heather Sankey **Date:** 1/26/2015
**Designation:** OB/GYN, Program Director **Telephone:** (413) 794-5321

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that **Ashley R Brant** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

**Designated Official's Name:** Martha Anderson **Date:** 2/3/2015
**Designated Official's Title:** Program Analyst, GME **Telephone:** (413) 794-8490

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
6-B. Have you, for any reason, been placed on probation in any postgraduate training program?

7. 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? [redacted]

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

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

10. 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).

11. 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).

12. 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?

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

14. Have you voluntarily relinquished medical staff membership?

15. 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?

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

17. 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?

18. Has any medical malpractice claim 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?

19. 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?

20. Have you been diagnosed with or do you have a medical condition which in any way limits or impairs your ability to practice medicine? If your answer is 'yes', describe the specifics of your condition and any related treatment, including dates and diagnoses.

21. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice medicine? If you have obtained medical treatment related to your use of chemicalsubstances, describe the specifics of the treatment, including dates and diagnoses.

[redacted]

## Compliance with Legal Responsibilities

1. I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

2. 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.

3. 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.

4. 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 ½.

5. 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.

6. 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.

7. I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00.

10. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

11. Under the penalties of perjury, I declare that I have examined this limited renewal 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. As an applicant for renewal of a limited 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.

☒ **I have reviewed the statements above that require me to understand and comply with specific requirements and I certify that I understand the responsibilities and obligations of each and agree to comply with said responsibilities and obligations.**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Limited Renewal Application

**Physician Name:** Ashley R Brant, D.O. **License No.:** 252584

1. **Training Program**

   **Current Training Program**

   **Facility:** Baystate Medical Center
   **Program:** Obstetrics and Gynecology

2. **Address & Contact Information**

   **Mailing Address:**
   Bay State Medical Center
   759 Chestnut Street
   Springfield
   Massachusetts - 01199
   United States of America

   **Home Address:** [redacted]

3. **Email Address:** [redacted]

4. **Massachusetts Limited License**
   Your current Massachusetts Limited License Number is: 252584

5. **Other states where you are now licensed to practice medicine**
   None Reported

**SECTION B: To be completed by the Program Director.**

Is the above named physician in good standing in the training program? [redacted]

Has the physician been subject to past or pending disciplinary action in this Program?

**Name:** Heather Sankey **Date:** 3/19/2014
**Designation:** OB/GYN, Program Director **Telephone:** (413) 794-5321

**To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.**

This certifies that **Ashley R Brant** has been appointed as **Resident**

Department of **Obstetrics and Gynecology**

Is the program accredited by the ACGME: Yes

**Designated Official's Name:** Martha Anderson **Date:** 3/20/2014
**Designated Official's Title:** Program Analyst, GME **Telephone:** (413) 794-8490

**6-A.** Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
**6-B.** Have you, for any reason, been placed on probation in any postgraduate training program?

**7.** 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? [redacted]

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

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

**10.** 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).

**11.** 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).

**12.** 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?

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

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**15.** 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?

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

**17.** 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?

**18.** Has any medical malpractice claim 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?

**19.** 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?

**20.** Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

**21.** Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?

**22.** Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?

**23.** Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?

**24.** Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?

**25.** Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? [redacted]

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☒ **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.**

Baystate



**Form**
**B**

## Medical School Verification Form

Applicants who are fourth year medical school students and who have completed the 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 Ashley R. Brant
(Student's Name)

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

from Michigan State University, College of Osteopathic Medicine
(Name of Medical School)

and will receive the degree on 05 / 04 / 12 .

Signature of Certifying Official: Sheryl Balmer-Hageman
(Original Signature is required – Stamps not accepted)

Printed Name: Sheryl Balmer-Hageman Title:

Date: 06/12/12

**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.**