File 16845

New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE IF YOU HAVE A CHANGE OF ADDRESS. PLEASE PRINT.

*****NOTE.....Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: Brenna C. Stupp, DO

N.H. License Number: 15680 (Exp 6/30/16)

Business Name: Manchester OBGYN Associates

☑ Address: 150 Tamtown Rd

Manchester, NH 03103

Office telephone: (603) 622-3162

Business Fax Number: [redacted] Business E-Mail: [redacted]

☐ Home Address: [redacted]

Home telephone: [redacted]

Specialty: OBGYN Board certified: Yes - Nov 2014

Hospital affiliations: Elliot Hospital

In what other states do you hold a current license: ø

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

May 2, 2012

BRENNA C STAPP DO
150 TARRYTOWN RD
MANCHESTER NH 03103

Dear Dr. Stapp:

Congratulations, the New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 15680, is dated May 2, 2012 and is enclosed with this letter.

Please make note of the expiration date. You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

Uniform Application for Physician Licensure

UA Username bcstapp **Date Submitted** 2/22/2012
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Stapp
First Name Brenna
Middle Name Corbett
Suffix
Maiden Name
M.D. ☐ **D.O.** ☒

All other names used

First	Middle	Last	Suffix
Brenna	Marie	Corbett	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
☐ **Public Access** **Street** 150 Tarrytown Rd
☒ **Mailing**
City Manchester **State/Province** NH **Zip Code** 03103
Country USA
Telephone 603-622-3162
Fax [redacted]
Email
Alternate Phone

Home
☒ **Public Access** **Street** 150 Tarrytown Rd
☐ **Mailing**
City Manchester **State/Province** MA **Zip Code** 03103
Country USA
Telephone 603-622-3162
Fax [redacted]
Email
Alternate Phone

b.g.c. sent 2/28/12

STAPP, BRENNA

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted]

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

[redacted]

Gender	Social Security Number	NPI	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** University Of Medicine and Dentistry of New Jersey - Osteopathic
Address One Medical Center Drive, Suite 210

City Stratford
State/Province NJ
ZIP Code 08084-1501
Country USA
Attendance Dates **From (mm/yyyy)** 08/2004 **To (mm/yyyy)** 05/2008
Graduation Date 5/21/2008
Degree DO

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** University of Connecticut
Hospital Address 263 Farmington Ave

City Farmington
State/Province Connecticut
ZIP Code 06030
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2008 **To:** 06 /2012 **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☒

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
NBOME - Comlex Level 1		06/2006	[X] P	[ ] F	1
NBOME - Comlex Level 2 CE		10/2007	[X] P	[ ] F	1
NBOME - Comlex Level 2 PE		10/2007	[X] P	[ ] F	1
NBOME - Comlex Level 3		03/2009	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure			
1	**State/Province**	**Practitioner Type (MD, DO, etc.)**	**Type of License (Full, Temporary, etc.)**
	License Number	**Status**	**Issue Date**

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2008 To: Month: Year: In Progress ☒	**Practice/Employment Name** UCONN Health Center (or list non-working time as indicated above) **Practice/Employment Address** 263 Farmington Ave **City** Farmington **State/Province** Connecticut **ZIP Code** 06030 **Country** USA **Position and Department** OBGYN Resident-OBGYN **Percent Clinical:** 80% **Percent Administrative:** 20% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Stapp
Applicant's Printed Last Name

Brenna C. Stapp
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

2/24/12
Date of Signature

NOTARY

Dated 2/24/12 Signed Rebecca Mayer

State of Connecticut County of Hartford.

SUBSCRIBED AND SWORN TO before me this 24 day of, February, 2012

My commission expires: April 30, 2013 (NOTARY PUBLIC SIGNATURE & SEAL)

REBECCA A. MAYER
NOTARY PUBLIC
State of Connecticut
My Commission Expires
April 30, 2013

Applicant Name: _____ Date: _____

ADDENDUM TO APPLICATION

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.**

	YES	NO
1. Have you been actively engaged in the practice of clinical medicine within the past 12 months?	X	
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).		X
3. Have you ever, for any reason, lost American Specialty Board Certification?		X
4. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		X
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).		X
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	X	
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?		X
8. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.)		X
9. Have you ever failed a foreign licensing or certification examination?		X
10. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		X
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?		X
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		X

STAPP, BRENNA

	YES	NO
13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	_____	___X___
14. Have you ever withdrawn an application for licensure, hospital privileges or appointment for any reason?	_____	___X___
15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?	_____	___X___
16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	_____	___X___
17. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?	_____	___X___
18. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?	_____	___X___

Anticipated Practice Location(s) (if known):

Manchester, NH; Londonderry, NH

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

SOCIAL SECURITY NUMBER: 021 – 62 – 3571

Applicant's Signature	Applicant's Printed Last Name	Date of Signature
	Banna C Stapp	1/15/12

For Board Use Only:

Application Received: 2/6, 2012 Fee Paid: $300- Check#: 1074

License Number: _____ Date of Issue: _____

BRENNA CORBETT STAPP, DO

[redacted]

EDUCATION

University of Connecticut Health Center — Farmington, CT
Resident in Obstetrics and Gynecology — 2008 – present

University of Medicine and Dentistry – School of Osteopathic Medicine — Stratford, NJ
Doctor of Osteopathic Medicine — 2004 – 2008

Ithaca College — Ithaca, NY
Honors Bachelor of Arts in Biology — 2000 - 2003
Minors: Spanish, Liberal Arts Honors Program; Pre-Medical Track

Saint Anselm College — Manchester, NH
Biology Major – Pre-Med Track — 1999 – 2000

PROFESSIONAL CERTIFICATIONS AND EXAMINATIONS

Advanced Cardiac Life Support Certified	June 2009
Neonatal Resuscitation Program Certified	July 2009
COMLEX Step 3 – Passed	March 2009
COMLEX Step 2 Clinical Knowledge Exam & Clinical Skills Exam - Passed	October 2007
COMLEX Step 1- Passed	June 2006
Certified Nurses Aide - American Red Cross	October 2003

HONORS AND AWARDS

University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine
Alumni Scholarship — 2005 – 2006

Ithaca College
Tri Beta Biology Honor Society — 2000 – 2003
Ithaca College Dean's List — 6 of 6 semesters

Saint Anselm College — 1999 - 2000
Saint Anselm College Dean's List — 2 of 2 semesters

LECTURES AND PRESENTATIONS

Grand Rounds – Hartford Hospital — January 5, 2012
"Cervical Insufficiency – To Stitch or Not To Stitch – What is the Evidence?" – Topic review of cervical insufficiency with focus on surgical management skills acquired while on elective with a specialist in cerclage.

American Assosciation of Gynecologic Laparoscopists — November 2011
"Laparoscopic Entry Technique – A Retrospective Review of the Last 2000 Cases" – AAGL Virtual Poster

Resident Research Night

"Making the Cut – Factoring in the Mode of Delivery at the Cusp of Viability" May 2011

Retrospective analysis on effects of mode of delivery on neonatal survival

Applied Medical GYN Cadaver Lab April 2011

Advanced laparoscopy course utilizing cadaveric models for laparoscopic hysterectomy and introduction to single port site surgery.

13th Annual Gynecologic Endoscopy Course April 2010

Invited attendee to a hands-on laparoscopy training course

Grand Rounds February 2010

"Pyelonephritis in Pregnancy" – The Hospital of Central Connecticut

Medical Spanish Course March 2012, April 2011 & October 2005

Guest lecturer to first year medical students to focus on history and physical specific to OB/GYN.
Taught weekly introductory Spanish vocabulary and conversation for medical interviewing and physical exam

APPOINTMENTS AND COMMITTEES

Aministrative Chief July 2011 – Present

Assist in scheduling, organization of conference attendance and learning experiences; intermediary between attending, nurse and resident interactions; assist in conflict resolution within the program

Resident Forum November 2011 - Present

Peer-selected representative for OB/GYN residency program on committee of university administrators and residents to supervise residency operations, policy changes and program reviews.

Labor and Delivery Culture Committee Fall/Winter 2011

Resident representative to improve communication and work flow on labor and delivery at Hartford Hospital

Obstetrics Q&A Committee July 2009 - Present

Chart review and case discussion for obstetric and neonatal complications

Education Committee July 2008 - Present

Resident representative for curriculum changes, practice algorithms and redesigning resident schedules for new work hour restrictions

VOLUNTEER EXPERIENCE

Hartford Public School 20th Annual Science Fair May 2011

Volunteer judge for K-3rd grade science fair projects

International Student Doctor

International Field Research Expeditions – Santa Elena, Ecuador April 8 – May 10th 2008

Assisted midwife and physician staff on labor and delivery for spontaneous and induced deliveries. Surgical assistant and scrub for caesarean deliveries, appendectomies and prolapse procedures. Emergency room triage and patient care.

International Student Doctor July 2005

Child Family Health International

Member of student healthcare team at urban and rural primary care sites throughout Quito, Ecuador; assisted with patient histories, physicals and surgical procedures in a wide variety of clinical settings. Completed 20 hour course in conversational and medical Spanish

Construction Volunteer December 2002

Presbyterian Disaster Relief – Orange Walk, Belize

Volunteer construction team to provide physical/monetary resources and manual labor to build a soup kitchen for community orphanage

Construction Volunteer December 2001

Presbyterian Disaster Relief - Miralagos, Nicaragua

Volunteer construction team to provide resources and manual labor to rebuild five homes destroyed by Hurricane Mitch. On-site Spanish-English translation for local construction team and volunteers

RESEARCH EXPERIENCE AND PUBLICATIONS

Luciano, D; Exacoustos, C; Corbett, B et al. *Assessment of the Uterine Junctional Zone Using 3D Transvaginal Ultrasound in Infertile and Fertile Patients With and Without Pelvic Endometriosis.* – Abstract accepted to ISUOG for 2011 conference.

"Laparoscopic Entry Technique – a Retrospective Review of Fifteen Years of Experience" November 2011

Accepted as virtual poster for AAGL 2011 Annual Congress.

Corbett, B. *"Delivering Miracles in South America".* The Journal, Vol. 5.4, Fall 2005

Hardwick, J. PhD; **Corbett, B.;** Dobson, J.S.; Powers, M.J. "Ionic Mechanisms of Histamine and Prostaglandin Modulation of Guinea Pig Intracardiac Neurons." Program No. 891.7. *2003 Abstract Viewer/Itinerary Planner.* Washington, DC: Society for Neuroscience, 2003. Online

Awarded Best Platform at Eastern College Science Conference, Ithaca, NY. (2003)

PROFESSIONAL MEMBERSHIPS

American Congress of Obstetrics and Gynecology – Junior Fellow	October 20, 2008 - present
American Association of Gynecologic Laparoscopists – Resident Member	May 8, 2010 - present
American Medical Assosciation – Resident Member	March 7, 2011 - present

PERSONAL INTERESTS

[redacted]

MAR 19 2014

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RECEIVED
MAR 17 2014
NH BOARD

RENEWAL APPLICATION

Renewal Fee: $350.00

For expiration on: 6/30/2016

For Office Use Only:
Date Pd: 3/17/14 Check # 35501

2 of 2

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y/N) N
(If yes, provide proof of board certification.)
Please list ABMS Board Specialty: _____

Currently licensed in the states of: (2 letter state abbrev.) NH _____ _____ _____ _____ _____

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 15680

File #: 16845

☐ Home Address

BRENNA C STAPP, DO
150 TARRYTOWN RD

MANCHESTER, NH 03103

Phone: 603-622-3162

☐ Work Address

150 TARRYTOWN RD

MANCHESTER, NH 03103

Please provide current Email, Fax and Phone Numbers below:

Phone: 603-622-3162
Business Fax Number:
Business Email Address: [redacted]

Hospital Affiliations: ***__Please list city and state where hospital is located.__ **Check off type of privileges you hold for each Hospital.**

Hospital Privileges	Full	Courtesy	Consult	Other
Elliot Hospital - Manchester, NH	☒	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Social Security Number:** [redacted]

Please answer each of the following questions. **If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?	___	✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with the secondary business address(es) and business phone number(s).	___	✓

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted)

3/10/14
Date

APR 07 2016

RECEIVED
APR - 7 2016
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RENEWAL APPLICATION

For expiration on: 06/30/2018

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 4/7/16 Check # 37941

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in business or home address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y)N) N
(If yes, provide proof of board certification.)
Please list ABMS Board Specialty: OBGYN

Currently licensed in the states of: (2 letter state abbrev.) NH

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 15680

File #: 16845

☑ Work Address

BRENNA C STAPP, DO
MANCHESTER OBGYN ASSOC
150 TARRYTOWN RD
MANCHESTER, NH 03103

Phone: 603-622-3162
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: [redacted]

Hospital Affiliations: **Please list city and state where hospital is located.**

Hospital Privileges

ELLIOT HOSPITAL	MANCHESTER	NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Last four (4) of your Social Security Number:** [redacted]

Please answer each of the following questions. **Affirmative answers to any question between 1 and 10 requires a complete written explanation of the circumstances, including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?	___	✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate?	___	✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).	___	✓
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	✓ error
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: NH Expiration Date: 2-28-2018	✓	___

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF UNSWORN FALSIFICATION THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted)

3/30/16
Date

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

October 19, 2015

RE: **Certification Status of Brenna Corbett Stapp, D.O.**

To Whom It May Concern:

Brenna Corbett Stapp, D.O. is a Diplomate of the American Board of Obstetrics & Gynecology (ABOG).

Obstetrics and Gynecology Certification

ABOG ID Number: 9028772
Original Certification Date: 11/7/2014
Certification Status: Valid through: 12/31/2015
Meeting Requirements of Maintenance of Certification: Yes

A physician becomes a Diplomate of the ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma.

Physicians certified by the ABOG in Basic Obstetrics and Gynecology prior to 1986 or subspecialty certified prior to November, 1987 hold non-time-limited (non-expiring) certificates. They are not required to participate in Maintenance of Certification.

Sincerely,

Larry C. Gilstrap III, MD

Larry C. Gilstrap, III, M.D.
Executive Director

A809968

RECEIVED
MAR 28 2018

STATE OF NEW HAMPSHIRE APR 17 2018

Telephone #: 603-271-6935

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RENEWAL APPLICATION

For Office Use Only:
Date Pd: 3/28/18 Check # 12666
$350

For expiration on: 06/30/2020 Renewal Fee: $350.00
If you **DO NOT** wish to renew your license, check here. ☐
If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes**. **Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in business or home address within 30 days of the change**.

Specialty: Obstetrics & Gynecology
Currently Board Certified? (Y/N) Yes **(If yes, provide proof of board certification.)**
Please list ABMS Board Specialty:
Currently licensed in the states of: (2 letter state abbrev.)

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 15680

☑ Work Address

BRENNA C STAPP, DO
MANCHESTER OBGYN ASSOC
150 TARRYTOWN RD
MANCHESTER NH 03103

☐ Home Address

BRENNA C STAPP, DO
[redacted]

Please provide current Email, Fax and Phone Numbers below:

PHONE: 6036223162
FAX: [redacted]
EMAI[redacted]

PHONE: [redacted]
FAX:
EMAIL: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located.**

ELLIOT HOSPITAL MANCHESTER NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Last four (4) of your Social Security Number:** [redacted]

Please answer each of the following questions. **Affirmative answers to any question between 1 and 10 requires a complete written explanation of the circumstances, including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate?		✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).		✓
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: NH Expiration Date: 2/28/21	✓	

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Signature of Licensee (Signature Stamp Not Accepted)

8/21/18
Date

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Medicine
121 South Fruit Street, Suite 301
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

SHERI WALSH
Division Director

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE IF YOU HAVE A CHANGE OF ADDRESS. PLEASE PRINT.

***NOTE.....Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: Brenna C. Staff, DO

N.H. License Number: NH 15680

Business Name: Manchester OBGYN Associates

☑ Address: 150 Tamytown Rd

Manchester, NH ~~03~~ 03103

Office telephone: (603) 622-3162

Business Fax Number: [redacted] Business E-Mail: [redacted]

☐ Home Address: [redacted]

[redacted] Home telephone: [redacted]

Specialty: OBGYN Board certified: yes

Hospital affiliations: Elliot Hospital

In what other states do you hold a current license: Ø

New Hampshire
MEDICAL SOCIETY ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

February 27, 2018

Brenna C Stapp, D.O.
Manchester OBGYN Associates
150 Tarrytown Rd
Manchester, NH 03103

CONGRATULATIONS

Dear Dr. Stapp:

You have met the continuing medical education requirements for the period from January 1, 2016 through December 31, 2017. The Board of Medicine for the State of New Hampshire will be so notified by this office.

Your next cycle will be from January 1, 2018 to December 31, 2019. You will not be required by the board to report CME until the end of 2019 , when you will be sent the appropriate forms. The forms are due back by February 28, 2020, following the end of your two-year cycle.

Physicians who possess a DEA license connected to a New Hampshire address will need to earn three (3) hours of Board-approved opioid CME as part of their regular CME cycle. Approved courses may be found on the NH Board of Medicine website: https://www.oplc.nh.gov/medicine/opoid-prescribing.htm.

If legislative changes to CME reporting requirements take effect we will notify you.

Sincerely,

Mary West

Mary West
Director of CME and Accreditation

Mary.West@nhms.org

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

March 21, 2018

RE: Certification Status of Brenna Corbett Stapp, D.O.

To Whom It May Concern:

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Physicians certified by the ABOG in Basic Obstetrics and Gynecology prior to 1986 or subspecialty certified prior to November, 1987 hold non-time-limited (non-expiring) certificates. They are not required to participate in Maintenance of Certification.

Sincerely,

George D. Wendel, Jr. M.D.
Executive Director

A752424