158690

State Medical Board of Ohio

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 med.ohio.gov

Ohio Physician Licensure Application

1. ***Indicate License Type*** ○ M.D. ◉ D.O. ○ M.D. Telemedicine ○ D.O. Telemedicine

2. ***Name: Indicate your full legal name. Please list any maiden names or other names used.***

Last	First	Middle	Suffix
Denny	Brittany	Victoria	

Maiden Name: Slaughter

All other names used: ϕ

3. ***Contact Information:*** *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ○ Practice Address ◉ Home Address

~~**Practice Address**~~ Home

Street 1: 25400 Fort Meigs Rd #17 — Phone Number: 734-347-8185

Street 2: — Fax Number:

City: Perrysburg — State: OH — Zip Code: 43551 — email: brittanyvictoria77@gmail.com

Home Address

Street 1: — Phone Number:

Street 2: — Fax Number:

City: — State: — Zip Code: — email:

4. ***Identification***

Date of birth	Birth City	State	Country
07/07/1986	Millersburg	OH	USA

SSN: [redacted]

Gender: ○ Male ◉ Female

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §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. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

Denny

PG# 137224

5. Preliminary Education.

High School or equivalent: Bedford High School

City: Temperance | State: MI | Country: USA

Date From: August 1999 | Date To: June 2004

Undergraduate College 1: Michigan State University

City: East Lansing | State: MI | Country: USA

Date From: August 2004 | Date To: July 2008 | Degree: Human Biology, B.S.

OK 21 5/8/17

Undergraduate College 2:

City: | State: | Country:

Date From: | Date To: | Degree:

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

The TOEFL, TWE, ECFMG's ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL-IBT.

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL-IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95 and 7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

○ YES ○ NO Have you completed two years of undergraduate college work in the United States?

○ YES ○ NO During the five years immediately preceding the date of your application have you:

Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?

○ YES ○ NO Have you completed a Fifth Pathway program?

○ YES ○ NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or after July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

◉ YES ○ NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name: Mercy St. ~~Vincent~~ Vincent Medical Center - Obstetrics & Gynecology

8. Military.

○ YES ◉ NO Are you currently in the United States Military or Reserves or a Military Veteran?

○ YES ◉ NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

9. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: Michigan State University College of Osteopathic Medicine
Address: 965 Fee Rd, East Fee Hall C110
City: East Lansing State: MI Zip Code:
Country: USA
Date From: June 2009
Date To: May 2013
Graduation Date: May 2, 2013
Degree: Doctor of Osteopathy

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

10. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: Mercy St. Vincent Medical Center
Address: 2213 Cherry St.
City: Toledo State: OH Zip Code: 43608
Country: USA
Department/Specialty: Obstetrics & Gynecology
Date From: July 2013
Date To: June 2017
Successfully Completed? ○ Yes ○ No
Graduation June 2017
PGY ○ 1 ○ 2 ○ 3 ◉ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

2. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ○ Yes ○ No
PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

3. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ○ Yes ○ No
PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

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4. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:
PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

5. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:
PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

11. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1		○ Pass ○ Fail	
USMLE Step 2 CK		○ Pass ○ Fail	
USMLE Step 2 CS		○ Pass ○ Fail	
USMLE Step 3		○ Pass ○ Fail	
COMLEX Level 1	6/24/11	◉ Pass ○ Fail	1
COMLEX Level 2 CE	7/23/12	◉ Pass ○ Fail	1
COMLEX Level 2 PE	5/8/12	◉ Pass ○ Fail	1
COMLEX Level 3	5/12/14	◉ Pass ○ Fail	1
NBME Part I		○ Pass ○ Fail	
NBME Part II		○ Pass ○ Fail	
NBME Part III		○ Pass ○ Fail	
NBOME Part I		○ Pass ○ Fail	
NBOME Part II		○ Pass ○ Fail	
NBOME Part III		○ Pass ○ Fail	
LMCC Part I		○ Pass ○ Fail	
LMCC Part II		○ Pass ○ Fail	
FLEX Componet 1		○ Pass ○ Fail	
FLEX Componet 2		○ Pass ○ Fail	
FLEX Pre-1985		○ Pass ○ Fail	

State Board Exam | Date Taken | State taken for | No. of Attempts | Pass / Fail ○ Pass ○ Fail

12. *ECFMG and Fifth Pathway*

Certificate Number | Issue Date

School Name | Date From
Address | Date To
City | State | Zip Code | Graduation Date
Country | Degree

13. *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 complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the 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. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status		Issue Date
1	Ohio	individual training (DO training certificate)	58.005234	(●) Active	( ) Inactive	10/21/13
2				( ) Active	( ) Inactive	
3				( ) Active	( ) Inactive	
4				( ) Active	( ) Inactive	
5				( ) Active	( ) Inactive	
6				( ) Active	( ) Inactive	
7				( ) Active	( ) Inactive	
8				( ) Active	( ) Inactive	
9				( ) Active	( ) Inactive	
10				( ) Active	( ) Inactive	
11				( ) Active	( ) Inactive	
12				( ) Active	( ) Inactive	
13				( ) Active	( ) Inactive	
14				( ) Active	( ) Inactive	
15				( ) Active	( ) Inactive	

14. *Specialty Board Certification:* *Are you ABMS and / or AOA certified?* ( ) Yes ( ) No

*If **Yes** complete information below*

Name of Board | Certificate Number | Issue Date
Name of Board | Certificate Number | Issue Date
Name of Board | Certificate Number | Issue Date

15. 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.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: ~~MAY 2013~~ | Year: 2013

TO: Month: June | Year: 2013 | ○ In Progress

Activity/Employer Name *(Non-Working*)*: Vacation

Activity Address: 7197 Hidden Lane Ct

City: Lamberville | State: MI | Zip Code: 48144

Position / Department: ϕ

Percent Clinical: | Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Time off before residency.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: June | Year: 2013

TO: Month: | Year: | ◉ In Progress

Activity/Employer Name *(Non-Working*)*: Mercy St. Vincent medical Center

Activity Address: 2213 Cherry St.

City: Toledo | State: OH | Zip Code: 43608

Position / Department: Resident

Percent Clinical: | Percent Administrative:

◉ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Residency training.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: | Year:

TO: Month: | Year: | ○ In Progress

Activity/Employer Name *(Non-Working*)*:

Activity Address:

City: | State: | Zip Code:

Position / Department:

Percent Clinical: | Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

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Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity/Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity /Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

16. *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 provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

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Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

○ Yes	⊗ No	1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
○ Yes	⊗ No	2. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?
○ Yes	⊗ No	3. Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?
○ Yes	⊗ No	4. Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?
○ Yes	⊗ No	5. Have you ever transferred from one graduate medical education program to another?
○ Yes	⊗ No	6. Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?
○ Yes	⊗ No	7. Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?
○ Yes	⊗ No	8. Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?
○ Yes	⊗ No	9. Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?
○ Yes	⊗ No	10. Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

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○ Yes	⊗ No	11. Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?
○ Yes	⊗ No	12. Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
○ Yes	⊗ No	13. Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
○ Yes	⊗ No	14. Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?
⊗ Yes	No	15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	⊗ No	16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	⊗ No	17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
○ Yes	⊗ No	18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
○ Yes	⊗ No	19. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?
○ Yes	⊗ No	20. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?
○ Yes	⊗ No	21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

22. a) INTENTIONALLY LEFT BLANK

22. b) INTENTIONALLY LEFT BLANK

*For purposes of questions **23** and **24** the following phrases or words have the following meaning:*

***"Ability to practice as a Physician"** is to be construed to include all of the following:*

1. *The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and*

2. *The ability to communicate those judgments and medical information to patients and other health care providers; and*

3. *The physical capability to perform medical tasks such as physical examination and surgical procedures.*

***"Medical condition"** includes physiological, mental, or psychological conditions or disorders, such as but not limited to visual, speech, and hearing impairments, cerebral palsy, epilepsy, multiple sclerosis, developmental disabilities, bipolar disorder, schizophrenia, tuberculosis, substance use disorder, rheumatoid arthritis, COPD, Parkinson's disease, mild cognitive impairment, Alzheimer's disease, spinal cord injury, brain injury, amputation and paralysis.*

***PLEASE NOTE:** Simply wearing corrective lenses does not constitute a visual impairment for purpose of this question. Any materials submitted regarding your medical condition are confidential under the Board's investigative authority under Section 4731.22(F)(5), Ohio Revised Code.*

○ Yes ✗ No 23. In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Section 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

N/A

○ Yes ○ No a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

N/A

○ Yes ○ No b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

○ Yes ✗ No 24. Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

○ Yes ○ No a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

N/A

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

○ Yes ○ No b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

N/A

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

○ Yes ✕ No 25. Are you currently engaged in the illegal use of controlled substances?

○ Yes ○ No a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.

This form must be completed if you have responded yes to Additional Information Question #I5 and/or #16.
Make additional copies of this form as needed.

Name of applicant: Brittany Denny

Date of incident: 4/12/2006

Location of Incident (City / State): Lansing, MI

Were you arrested:
○ Yes ◉ No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?

If Yes, type if test and result: N/A

What offense(s) were you charged with? Person under 21 consuming alcohol

Were the charges amended?:
○ Yes ◉ No

If Yes, what were the final charges: N/A

Disposition:
○ Pending ○ Charges Dismissed ○ Charges Dropped ◉ Conviction
◉ Plea: Guilty.
○ Other:

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

-please attached pages

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

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Brittany Denny

25400 Fort Meigs Rd #17 • Perrysburg, OH 43551 • Phone: 734-347-8185
E-Mail: brittanyvictoria77@gmail.com

Date: April 22, 2017

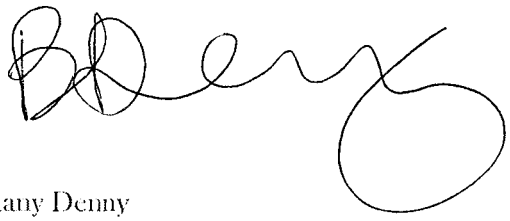
To Whom It May Concern:

On April 12, 2006, I was ticketed at a bowling alley in Lansing, MI. The charge was "Person under 21, in possession of alcohol." A police officer was called to the bowling alley. She did not perform a Breathalyzer test nor was I arrested. I presented to 54-A District Court on May 16, 2006. I plead guilty to the charge. I was thus issued 20 hours of community service and completion of an alcohol awareness course. I completed both of these requirements and my case was closed. I have enclosed the documentation I was able to obtain. The case was closed and I was not placed on probation.

Since that time, I have matured. I came to understand that underage drinking is illegal and that the consequences of my actions were not worth drinking underage at a bowling alley. I have continued to only consume alcohol in moderation and never before driving.

Please contact me with further questions or concerns.

Sincerely,



Brittany Denny

54-A DISTRICT COURT

124 W. Michigan Ave., 6th Floor City Hall, Lansing, MI 48933

CERTIFICATE OF CONVICTION

State of Michigan, County of Ingham, City of Lansing

Pursuant to MCL 768.22(2), I, the undersigned official of the District Court for the 54-A Judicial District of the State of Michigan, hereby certify that I have examined the original records of the Court, and those records contain the following information of conviction:

Name:	BRITTANY VICTORIA SLAUGHTER
Address - Street	3156 BEAUJARDIN
City/State/Zip Code:	LANSING, MICHIGAN 48911
Date of Birth:	07/07/1986
Driver License Number:	NONE LISTED
Case number(s):	06-03103-OM
Conviction date:	05/10/2006
Judge	HONORABLE LOUISE ALDERSON
Charge:	PERSON UNDER 21
	PURCHASE/CONSUME/POSSSESS LIQUOR
PACC:	1360

I hereby certify that the requested information is not disclosed in the court records for all of the above that are marked as N/A.

I hereby certify that I have compared the foregoing with the original, and it is a true and correct abstract of the conviction, as provided by law, of said defendant.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seal of the 54-A District Court this date, at the City of Lansing, MI

Irene B — Deputy Court Clerk

March 22, 2017
Today's Date

State Medical Board of Ohio

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 med.ohio.gov

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 or shall make with respect thereto are true, that I am the original and lawful possessor 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 licensure or permit to practice medicine.

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

Denny
Applicant's Printed Last Name

Britlany V
Applicant's Printed First Name, Middle Initial and Suffix (e.g., Jr.)

3/17/17
Date of Signature

Christie C. Hathaway
Notary Public Signature

1-31-2020
Date Commission Expires

Subscribed and Sworn to before me on this 17 day of MARCH ,20 17

CHRISTINE C. HATHAWAY
Notary Public - State of Ohio
My Commission Expires 01-31-2020

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Denny, Brittany Victoria**
Social Security Number:	Redacted
Date of Birth:	**July 07, 1986**
FID#:	**302387931**
Recipient:	**OH - State Medical Board of Ohio**
Delivery Date:	**05/02/2017**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 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 me 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

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

Denny

Applicant's **Printed** Last Name

Brittany V

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

3/17/17

Date of Signature (**must** correspond to date of notarization)

State of OHIO, County of LUCAS,

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 17 day of MARCH, 2017.

Notary Public Signature: Christie C Hathaway

My Notary Commission Expires: 1-31-2020

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL(817)868-5000

FCVS ID Number
FCVS
302 387 931

FID Number
302387931

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Federation of STATE MEDICAL BOARDS

Biographic Information

Medical professional Name(s):	**Denny, Brittany Victoria**
	Slaughter, Brittany Victoria
Date of Birth:	July 07, 1986
Place of Birth:	Millersburg, OH, UNITED STATES

Contact Information

Home Address:	25400 Fort Meigs Rd #17 Perrysburg, OH 43551 UNITED STATES
Mobile Phone:	(734) 347-8185
Email:	brittanyvictoria77@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Denny Brittany Victoria
Last First Middle

FCVS ID Number: FCVS

Notary – Please complete the section below:

State of OHIO County of LUCAS

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Valid Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this

(Day) 17, of (Month) MARCH, (Year) 2017.

Notary Public Signature: Christine C. Hathaway

Commission Expiration Date* (Month) 1 / (Day) 31 / (Year) 2020

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

CHRISTINE C. HATHAWAY
Notary Public - State of Ohio
My Commission Expires 01-31-2020

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd
Euless, TX 76039-3856

FCVS ID Number
FCVS

FID Number
302387931

302 387 931 ND

We the People

Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.

Brittany Denny

SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. du Passeport / No. de Pasaporte: 496391333

Surname / Nom / Apellidos
DENNY

Given Names / Prénoms / Nombres
BRITTANY VICTORIA

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
07 Jul 1986

Place of birth / Lieu de naissance / Lugar de nacimiento
OHIO, U.S.A.

Sex / Sexe / Sexo
F

Date of issue / Date de délivrance / Fecha de expedición
25 Oct 2012

Authority / Autorité / Autoridad
United States
Department of State

Date of expiration / Date d'expiration / Fecha de caducidad
24 Oct 2022

Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27

USA

P<USADENNY<<BRITTANY<VICTORIA<<<<<<<<<<<<<<<<
496391333USA8607070F2210241253839552<027386

Lucas County Probate Court

700 ADAMS STREET, SUITE 200, TOLEDO, OHIO 43624-1676
TELEPHONE (419) 213-4775 FASCIMILE (419) 213-4764
e-mail address – information@lucas-co-probate-ct.org
Web Site – www.lucas-co-probate-ct.org

Certified Copy of Marriage Record

THE STATE OF OHIO,)
) **ss.**
LUCAS COUNTY,)

Case Number: 2010 MRG 002578

I, JACK R. PUFFENBERGER, certify that I am Judge of the Probate Court, within and for said county, which is a Court of Record, that I am Clerk of said Court, and by law the custodian of the records and papers required by law to be kept in said Court, and that among others a Record of Marriages was heretofore required by law to be kept therein, and that the following is a true and correct copy from said Record of Marriages, now in this office.

I do hereby certify that on ***08/06/2010***, I solemnized the marriage of ***Mr. Christopher Stephen Denny*** *(date of birth 08/11/1986)* with ***Ms. Brittany Victoria Slaughter*** *(date of birth 07/07/1986)*.

Ceremony performed by
Rev William R. Bauman

In TESTIMONY WHEREOF I have hereunto set my hand and the seal of The Probate Court, at Toledo, Ohio, this **17 August 2010**

Jack R. Puffenberger
Judge and Clerk of the Probate Court of said County

By _____ Deputy Clerk

Christopher Stephen Denny
4857 Battery Ln
Bethesda, MD 20814

LCPC-1 (REV. 12/99)

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
06/01/2009	06/03/2013	Medical Education	Michigan State University College of Osteopathic Medicine East Lansing Michigan UNITED STATES
07/01/2013	06/30/2017	Postgraduate Training	Mercy St Vincent MC Toledo Ohio UNITED STATES

End of Chronology of Activities report for: Denny, Brittany Victoria

Medical Education

Medical Education

Medical School: **Michigan State University College of Osteopathic Medicine**

Location: East Lansing, MI
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Michigan State University College of Osteopathic Medicine

Address Line 1: A314 East Fee Hall

Address Line 2:

City: East Lansing **State/Province:** MI **Zip Code (Postal Code):** 488241316

Country: US

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school: 2
Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that Denny, Brittany Victoria
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 201 weeks of medical education on the following dates: **From:** 06/25/2009 **To:** 05/03/2013
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Osteopathic Medicine on 05/03/2013
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Name: Teresa Zdenahlik

Signature: *Teresa Zdenahlik*

Title: Records Associate
Date of Signature: 04/10/2017 **Phone:** (517) 353-7741
Fax: (517) 432-1976 **Email:** Teresa.zdenahlik@hc.msu.edu

302387931 1046 302387931

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **No**

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

	From Date:	**To Date:**
Personal/Family_____		
Academic remediation_____		
Health _____		
Financial _____		
Participation in joint degree Program (e.g., MD/PhD)		
Participation in non-research special study		
(e.g., fellowship, international experience)_____		
Participation in non-degree research _____		
Other:		
Other:		

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **No**

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

	From Date:	**To Date:**
Academic Probation _____		
Probation for unprofessional conduct/behavioral _____		
Other:		

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **No**

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Denny, Brittany Victoria

Michigan State University College of Osteopathic Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Denny, Brittany Victoria

MICHIGAN STATE
UNIVERSITY

April 10, 2017

Dear Program Director:

This letter is an evaluation of the achievements of Ms. Brittany V. (Slaughter) Denny who is applying for post-graduate training following her graduation from this College with a Doctor of Osteopathic Medicine (D.O.) degree, which is expected in May of 2013. Ms. Denny received a B.S. degree in Human Biology from Michigan State University (East Lansing, MI) in August of 2008. Her work experience prior to entering this College has included being a Nanny, Child Care Provider, Indexer, Cashier at McAlister's Deli, Child Care Provider at The Latchkey Center, and Busser/Hostess/Waitress at Café Marie.

Ms. Denny entered the professional program in this College Summer Semester, 2009. While a student in this College, her performance—personally, professionally and academically—has been very good. She successfully passed all of her Preclerkship Program courses (almost all above 83%) and had outstanding academic performances (88% or better or 90th percentile or better) in the following: Molecular Biology and Medical Genetics, Cell Biology and Physiology I and II, Medical Neuroscience, Clinical Skills I, Neuromusculoskeletal System I, Radiology, Gastrointestinal, Reproductive, Growth and Development, Hematopoietic, Integumentary and Cases in Growth & Development Systems Biology courses.

In addition to her regularly scheduled courses, Ms. Denny took elective coursework. She participated in elective courses such as OMM Shadowing Experience, OMM Student Clinic, and the Pediatric Healthy Habits Community Project. Ms. Denny was awarded membership to Sigma Sigma Phi National Osteopathic Honors Society. She was also the recipient of the Walter J. Laird Memorial Endowed Scholarship for the 2010/2011 academic year. The above record attests to her academic ability and propensity for becoming an osteopathic physician and dealing with issues facing an osteopathic physician.

In addition to Ms. Denny's role as a student, she found time to be involved in community service and volunteer activities which were not included as part of the regular curricular program. She participated actively in the Community Integrated Medicine (CIM) electives in which she helped provide healthcare screening and education to the medically underserved in the community. She was also active with the MSUCOM Open House (2010 and 2011), Super All Year Free Clinic, (2011), Detroit Rescue Mission Soup Kitchen (2010 and 2011), OMM Free Clinic (2010 and 2011), Senior Physicals (2010), Legislative Flu Shots (2009), Teddy Bear Picnic (2009) and Admitted Student Tours (2009 and 2011).

College of Osteopathic Medicine

Office of Student Services

C110 East Fee Hall
East Lansing, MI 48824

517-353-7741
Fax: 517-432-1976

Ms. Denny also found the time to be involved in various student/medical organizations such as the Student Osteopathic Medical Association (SOMA), Student Government Association (Director of Events), OMM Free Clinic (development committee member), Undergraduate American Academy of Osteopathy (UAAO), American College of Osteopathic Family Physicians (ACOFP), American Medical Women's Association (AMWA), Admissions Committee (student representative) and Michigan Osteopathic College Foundation Board (student representative). She also attended DO Day on the Hill (Washington, D. C., Mar 2011) and the Michigan Osteopathic Annual Convention (Dearborn, MI, May 2010).

Ms. Denny's dedication, energy and sensitivity to community service and her fellow students, along with the obvious commitment to osteopathic medicine, are noteworthy and laudable at her stage of life. Her future is indeed bright and the osteopathic profession and any community in which Ms. Denny resides and practices will truly be fortunate.

Ms. Denny took the NBOME COMLEX Level 1 examination in June of 2011 and passed with a score of 515. She passed the COMLEX Level 2PE examination in May of 2012. These speak highly to her solid basic science and clinical knowledge base and the excellent foundation that she has for the study of clinical medicine.

In the Clerkship Program Ms. Denny's performance has been "Very Good/Outstanding."

For the Primary Care Ambulatory Clerkship (PCAC) clinical rotations, Ms. Denny was rated in the 6 to 7 ranges, with 7 being the highest rating a student could achieve and 4 the average, in the following areas: history-taking, physical examination, problem-solving, record-keeping, student/patient interaction, health maintenance and promotion, professional development, motivation and knowledge in Addiction Medicine, ENT, Family Medicine, Internal Medicine, and Pediatrics. Her overall assessment ratings were as follows: Addiction Medicine (7), ENT (6), Family Medicine (6.5 and 7), Internal Medicine (6.5), and Pediatrics (6). Ms. Denny's clinical instructors commented on her being *"an excellent student, very interested in addiction medicine, a quick learner, and she will make a wonderful doctor"* (Addiction Medicine); *"an excellent student, keen interest and desire to learn, and she will be an asset to our profession"* (ENT); *"excellent job, she works well, went above and beyond, and he had a great*

repertoire with both patients and staff" (Family Medicine); *"wonderful personality, well-liked by patients and staff, hardworking, energetic, and well-suited for primary care"* (Family Medicine); *"extremely well motivated, personable, confident, she quickly establishes rapport with patients and gains their trust"* (Internal Medicine); and *"her physical exam skills, differentials and management improved, very good bedside manner, very enthusiastic, eager to learn, very positive, and good clinical acumen"* (Pediatrics).

For her Clinical Rotations (Anesthesia, Emergency Medicine, General Surgery, Internal Medicine, OB/GYN, Psychiatry, Radiology), Ms. Denny was evaluated in the "Satisfactory/At Expected Level/Competent," "Above Average" and "Exceptional/Superior/Exceeds Expectations" categories in history taking, physical examination, clinical problem solving, record keeping, osteopathic principles, professional development, motivation, knowledge, psychomotor skills and daily log. She received overall assessments of "Satisfactory/At Expected Level/Competent," (Emergency Medicine) "Above Average" (Anesthesia, General Surgery, OB/GYN, Radiology) and "Exceptional/Superior/Exceeds Expectations" (Internal Medicine, Psychiatry). Ms. Denny's clinical instructors commented *"her skills and knowledge are excellent"* (Emergency Medicine); *"she was helpful, attentive, and patients like her"* (General Surgery); *"an outstanding student, she functions at the level of an early intern, very thorough notes including diagnosis and treatment, she makes independent medical decisions, and she is confident"* (Internal Medicine); *"she did a great job, gave good presentations, always progressed, and her knowledge base was above her level of training"* (Internal Medicine); *"an eager learner, she had an enthusiastic approach to the rotation, integrated well with the team, very reliable, trustworthy, and she will do well in OB/GYN if she chooses to pursue this specialty"* (OB/GYN); *"culturally sensitive, warm and professional to patients and their families, accurate and reasonable treatment plan, obtains excellent history, impressive use of collected data, she always accepts responsibility for her decisions, she is moral, honest, has very good communication skills, and she improves with feedback"* (Psychiatry); and *"she did well on the rotation"* (Radiology).

No significant issues were noted. As with all students at this level of training, there is always a need for more clinical experience, which will come with time, and additional experience with/exposure to clinical medicine and patient care responsibilities. Ms. Denny has all the clinical tools necessary to make her an outstanding osteopathic physician.

In summary, this Office recommends Ms. Brittany V. (Slaughter) Denny for post-graduate training with high regard. There is every indication that she will make an excellent contribution to your program.

Very truly yours,

William M. Falls, Ph.D.
Associate Dean/Student Services

bjs

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

DENNY, BRITTANY VICTORIA

STUDENT ID: A34743946

COURSE	TITLE	CRS	GRADE	S R	H

PREVIOUS/TRANSFER INSTITUTIONS
BEDFORD SENIOR HIGH SCHOOL ATTENDED: 08/00 - 06/04
TEMPERANCE MI

UNDERGRADUATE CREDIT
ADVANCED PLACEMENT

MSU SEM CREDITS ACCEPTED: 0.00

UNDERGRADUATE CREDIT

COURSE INFORMATION

FALL SEMESTER 2004 08/30/04 - 12/17/04

KIN	107B	RACQUETBALL I	1	P	
LBS	171	CHEMISTRY I - STRUCTURE	4	3.5	H
LBS	171L	CHEMISTRY I - LABORATORY	1	3.5	
MTH	116	COLLEGE ALGEBRA & TRIGONOMETRY	5	3.5	
PSY	101	INTRODUCTORY PSYCHOLOGY	4	4.0	H

CUM CREDITS : 15.0 CUM GPA : 3.6428
DEAN'S LIST

SPRING SEMESTER 2005 01/10/05 - 05/06/05

LBS	144	BIOLOGY I: ORGANISMAL BIOLOGY	4	4.0	
LBS	172	CHEMISTRY II - REACTIVITY	3	3.0	
LBS	172L	CHEMISTRY II - LABORATORY	1	3.5	
MTH	132	CALCULUS I	3	4.0	
PHL	200	INTRODUCTION TO PHILOSOPHY	3	4.0	

CUM CREDITS : 29.0 CUM GPA : 3.6964
DEAN'S LIST

FALL SEMESTER 2005 08/29/05 - 12/16/05

BS	111	CELLS AND MOLECULES	3	3.5	
BS	111L	CELL AND MOLECULAR BIOLOGY LAB	2	3.5	
PHY	231	INTRODUCTORY PHYSICS I	3	3.5	
TE	150	REFLECTIONS ON LEARNING	3	4.0	H
TE	250	HUM DIV POWER & OPP SOC INST	3	4.0	

CUM CREDITS : 43.0 CUM GPA : 3.7023
DEAN'S LIST

SPRING SEMESTER 2006 01/09/06 - 05/05/06

CEM	251	ORGANIC CHEMISTRY I	3	4.0	
CEM	262	QUANTITATIVE ANALYSIS	3	3.0	
ISS	210	SOCIETY AND THE INDIVIDUAL (D)	4	4.0	H
PSL	250	INTRODUCTORY PHYSIOLOGY	4	4.0	
STT	421	STATISTICS I	3	3.5	

CUM CREDITS : 60.0 CUM GPA : 3.7118
DEAN'S LIST

SUMMER SEMESTER 2006 05/13/06 - 08/18/06

PHY	232C	INTRODUCTORY PHYSICS II	3	3.0	

CUM CREDITS : 63.0 CUM GPA : 3.6774

FALL SEMESTER 2006 08/28/06 - 12/15/06

CEM	252	ORGANIC CHEMISTRY II	3	4.0	
CEM	253	ORGANIC CHEMISTRY LABORATORY	2	4.0	
HST	320	HISTORY OF MICHIGAN	3	3.5	
PHY	251	INTRO PHYSICS LAB I	1	3.5	
TE	302	LRNERS & LRNING IN CONTEXT-SEC	4	4.0	

CUM CREDITS : 76.0 CUM GPA : 3.7066
DEAN'S LIST

----------END OF COLUMN----------

SEAL VERIFIED

302 387 9371

COURSE	TITLE	CRS	GRADE	S R	H

SPRING SEMESTER 2007 01/08/07 - 05/04/07

ANTR	350	HUMAN GROSS ANATOMY STRUC BIOL	3	3.5	
BMB	401	BASIC BIOCHEMISTRY	4	3.5	
HNF	150	INTRO TO HUMAN NUTRITION	3	4.0	H
MMG	301	INTRODUCTORY MICROBIOLOGY	3	3.5	
MMG	302	INTRO MICROBIOLOGY LAB	1	3.0	

CUM CREDITS : 90.0 CUM GPA : 3.6853
DEAN'S LIST

FALL SEMESTER 2007 08/27/07 - 12/14/07

BMB	462	BIOCHEMISTRY II	3	3.5	
MMG	451	IMMUNOLOGY	3	4.0	
NSC	495	CAPSTONE IN HUMAN BIOLOGY (W)	2	4.0	
PSL	431	HUMAN PHYSIOLOGY I	3	4.0	
WRA	195H	WRITING: MAJOR TOP AMER THGHT	4	4.0	H

CUM CREDITS : 105.0 CUM GPA : 3.7163
DEAN'S LIST

SPRING SEMESTER 2008 01/07/08 - 05/02/08

EPI	390	DISEASE IN SOCIETY	4	3.0	
MMG	409	EUKARYOTIC CELL BIOLOGY	3	3.5	
PSL	432	HUMAN PHYSIOLOGY II	3	3.5	
PSY	280	ABNORMAL PSYCHOLOGY	3	4.0	

CUM CREDITS : 118.0 CUM GPA : 3.6880

SUMMER SEMESTER 2008 05/12/08 - 06/26/08

PSY	320	HEALTH PSYCHOLOGY	3	4.0	
ZOL	341	FUNDAMENTAL GENETICS	4	4.0	

SUMMER SEMESTER 2008 06/30/08 - 08/23/08

HST	487	SEM IN COMPARATIVE HISTORY (W)	3	4.0	H

LONDON UNITED KINGDOM

SUMMER SEMESTER 2008 06/30/08 - 08/24/08

PHL	491	SPECIAL TOPICS IN PHILOSOPHY	4	4.0	H

LONDON UNITED KINGDOM

CUM CREDITS : 132.0 CUM GPA : 3.7213
DEAN'S LIST

BACHELOR OF SCIENCE GRANTED: 08/14/08
MAJOR: HUMAN BIOLOGY
COLLEGE: NATURAL SCIENCE
WITH HONOR
MEMBER OF THE HONORS COLLEGE

SPECIALIZATION UNDERGRADUATE GRANTED: 08/14/08
BIOETHICS,HUMANITIES & SOCIETY

OSTEOPATHIC MEDICINE CREDIT

COURSE INFORMATION

SUMMER SEMESTER 2009 06/30/09 - 08/24/09

ANTR	551	MEDICAL GROSS ANATOMY	6	P

CUM CREDITS : 6.0 CUM GPA : N/A

----------CONTINUED ON PAGE 02----------

PROVIDED SOLELY FOR: (1)
FEDERATION CREDENTIALS VERIFICATION
SERVICES
FEDERATION OF STATE MEDICAL BOARDS
400 FULLER WISER RD
EULESS TX 76039 9977

Nicole G Rovig
University Registrar

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MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

DENNY, BRITTANY VICTORIA

STUDENT ID: A34743946

COURSE	TITLE	CRS	GRADE	S R	H
OSTEOPATHIC MEDICINE CREDIT					
FALL SEMESTER 2009 08/31/09 - 12/18/09					
BMB 514	MEDICAL BIOCHEMISTRY	3	P		
BMB 526	GENETICS	2	P		
OST 504	DOCTOR/PATIENT RELATIONSHIP	2	P		
OST 531	BIOSTATISTICS & EPIDEMIOLOGY	2	P		
PSL 534	CELL BIOLOGY AND PHYSIOLOGY I	3	P		
FALL SEMESTER 2009 09/02/09 - 12/18/09					
FCM 590	SPEC PROB IN FAMILY MEDICINE	1	P		
OMM 501	OMM I	1	P		
CUM CREDITS : 20.0	CUM GPA : N/A				
SPRING SEMESTER 2010 01/11/10 - 03/26/10					
PSL 535	CELL BIOLOGY AND PHYSIOLOGY II	4	P		
SPRING SEMESTER 2010 01/11/10 - 05/07/10					
FCM 590	SPEC PROB IN FAMILY MEDICINE	1	P		
MMG 522	MEDICAL MICROBIO & IMMUNOLOGY	5	P		
NOP 552	MEDICAL NEUROSCIENCE	4	P		
OMM 502	OMM II	1	P		
OST 501	CLINICAL SKILLS	4	P		
PED 590	SPECIAL PROBLEMS IN PEDIATRICS	1	P		
SPRING SEMESTER 2010 03/29/10 - 05/07/10					
HM 561	BASIC PRINCIPLES OF PATHOLOGY	2	P		
CUM CREDITS : 42.0	CUM GPA : N/A				
SUMMER SEMESTER 2010 05/17/10 - 07/01/10					
PHM 563	MEDICAL PHARMACOLOGY	3	P		
RAD 553	INTRODUCTION TO RADIOLOGY	1	P		
SUMMER SEMESTER 2010 05/17/10 - 08/09/10					
OST 511	SYS BIO NEUROMUSCULOSKLTL I	7	P		
SUMMER SEMESTER 2010 05/18/10 - 06/17/10					
OMM 503	OMM III	1	P		
CUM CREDITS : 54.0	CUM GPA : N/A				
FALL SEMESTER 2010 07/29/10 - 10/05/10					
FCM 650	PRIN OF FAM MED - INTENSIVE	1	P		
FALL SEMESTER 2010 08/30/10 - 10/04/10					
OST 512	SYS BIO NEUROMUSCULOSKLTL II	5	P		
OST 528	SYS BIO: GROWTH & DEV	2	P		
FALL SEMESTER 2010 09/01/10 - 12/17/10					
FCM 590	SPEC PROB IN FAMILY MEDICINE	1	P		
FCM 640	PRINCIPLES OF FAMILY MEDICINE	1	P		
OMM 500	STUDENT OMM PRACTICAL LAB	1	P		
OMM 504	OMM IV	1	P		
FALL SEMESTER 2010 09/27/10 - 10/25/10					
OST 529	SYS BIO ENDOCRINOLOGY	2	P		
FALL SEMESTER 2010 09/29/10 - 11/01/10					
OST 522	SYS BIO GASTROINTESTINAL	5	P		
FALL SEMESTER 2010 10/27/10 - 12/13/10					
OST 536	BEHAVIORAL SYSTEM	3	P		
FALL SEMESTER 2010 11/01/10 - 12/13/10					
OST 527	SYS BIOLOGY: FEMALE REPRO	4	P		
CUM CREDITS : 80.0	CUM GPA : N/A				
SPRING SEMESTER 2011 01/10/11 - 01/31/11					
OST 538	CHRONIC ILLNESS	1	P		
SPRING SEMESTER 2011 01/10/11 - 02/28/11					
OST 521	SYS BIO HEMATOPOIETIC	2	P		
SPRING SEMESTER 2011 01/10/11 - 03/07/11					
OST 524	SYS BIO CARDIOVASCULAR	8	P		
SPRING SEMESTER 2011 01/10/11 - 05/06/11					
FCM 590	SPEC PROB IN FAMILY MEDICINE	1	P		
OMM 500	STUDENT OMM PRACTICAL LAB	1	P		
OMM 505	OMM V	1	P		
OMM 590	SPEC PROBLEMS IN BIOMECHANICS	1	P		
SPRING SEMESTER 2011 03/14/11 - 04/04/11					
OST 523	SYS BIO GENITOURINARY	3	P		
SPRING SEMESTER 2011 03/14/11 - 04/30/11					
OST 519	ETHICS, POLICY & JURISPRUDENCE	2	P		
SPRING SEMESTER 2011 03/14/11 - 05/04/11					
OST 525	SYSTEMS BIOLOGY: RESPIRATORY	6	P		
CUM CREDITS : 106.0	CUM GPA : N/A				
SUMMER SEMESTER 2011 04/13/11 - 06/13/11					
OST 532	SYS BIO: GROWTH & DEV CASES	1	P		
SUMMER SEMESTER 2011 05/09/11 - 06/10/11					
OST 526	SYS BIO INTEGUMENTARY	2	P		
SUMMER SEMESTER 2011 05/16/11 - 08/18/11					
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
CUM CREDITS : 121.0	CUM GPA : N/A				
FALL SEMESTER 2011 08/31/11 - 12/16/11					
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
OST 602	PRIMARY CARE AMBULATORY CLKSHP	6	P		
CUM CREDITS : 145.0	CUM GPA : N/A				
SPRING SEMESTER 2012 01/02/12 - 03/01/12					
IM 650	MEDICINE CLERKSHIP	6	P		
SPRING SEMESTER 2012 01/30/12 - 04/01/12					
OSS 653	SURGERY CLERKSHIP	6	P		
SPRING SEMESTER 2012 02/27/12 - 05/01/12					
PSC 608	PSYCHIATRY & BEHAV SCI CLKSHP	6	P		
SPRING SEMESTER 2012 03/26/12 - 06/01/12					
OSS 651	OBSTETRICS & GYNECOLOGY CLKSHP	6	P		
CUM CREDITS : 169.0	CUM GPA : N/A				

----------CONTINUED ON PAGE 03----------

----------END OF COLUMN----------

302 387 931

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FEDERATION OF STATE MEDICAL BOARDS
400 FULLER WISER RD
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Nicole G Rovig
University Registrar

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MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

DENNY, BRITTANY VICTORIA

STUDENT ID: A34743946

COURSE	TITLE	CRS	GRADE	S R	H
OSTEOPATHIC MEDICINE CREDIT					
SUMMER SEMESTER 2012 04/30/12 - 05/27/12					
IM 657	EMERGENCY MEDICINE CLERKSHIP	6	P		
SUMMER SEMESTER 2012 05/14/12 - 08/16/12					
OMM 602	OSTEOPATHIC PRINCIPLES & PRACT	2	P		
SUMMER SEMESTER 2012 05/28/12 - 06/24/12					
IM 650	MEDICINE CLERKSHIP	6	P		
SUMMER SEMESTER 2012 07/02/12 - 07/29/12					
OSS 654	ANESTHESIOLOGY CLERKSHIP	3	P		
RAD 609	RADIOLOGY CLERKSHIP	4	P		
SUMMER SEMESTER 2012 07/30/12 - 08/26/12					
OSS 651	OBSTETRICS & GYNECOLOGY CLKSHP	6	P		
CUM CREDITS : 196.0	CUM GPA : N/A				
FALL SEMESTER 2012 08/27/12 - 09/23/12					
OSS 651	OBSTETRICS & GYNECOLOGY CLKSHP	6	P		
FALL SEMESTER 2012 09/24/12 - 10/21/12					
OSS 651	OBSTETRICS & GYNECOLOGY CLKSHP	6	P		
FALL SEMESTER 2012 10/22/12 - 11/18/12					
IM 654	PULMONARY DISEASE CLERKSHIP	6	P		
FALL SEMESTER 2012 11/19/12 - 12/16/12					
OSS 651	OBSTETRICS & GYNECOLOGY CLKSHP	6	P		
CUM CREDITS : 220.0	CUM GPA : N/A				
SPRING SEMESTER 2013 12/31/12 - 02/15/13					
IM 621	CLIN TROPICAL MEDICINE CLKSHP	9	P		
	CHOGORIA KENYA				
SPRING SEMESTER 2013 01/28/13 - 02/24/13					
RAD 609	RADIOLOGY CLERKSHIP	4	P		
SPRING SEMESTER 2013 02/25/13 - 03/24/13					
IM 650	MEDICINE CLERKSHIP	6	P		
CUM CREDITS : 239.0	CUM GPA : N/A				

DOCTOR OF OSTEOPATHIC MEDICINE GRANTED: 05/03/13
MAJOR: OSTEOPATHIC MEDICINE
COLLEGE: OSTEOPATHIC MEDICINE
----------NO ENTRIES BELOW THIS LINE----------

302 387 991

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FEDERATION OF STATE MEDICAL BOARDS
400 FULLER WISER RD
EULESS TX 76039 9977

Nicole G Rovig
University Registrar

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MICHIGAN STATE UNIVERSITY

Office of the Registrar
Hannah Administration Building
426 Auditorium Road, Room 150
East Lansing, MI 48824-0210
Telephone (517) 355-3300

This information is confidential. Its release is governed by the Family Education Rights and Privacy Act (FERPA) of 1974, as amended and the Michigan State University Access to Student Information policy. FERPA prohibits the release of this record or disclosure of its contents to any other party without written consent from the student.
Alteration of this transcript may be a criminal offense.

Accreditation

Michigan State University is a member of the Association of Public and Land-grant Universities, Association of American Universities, American Council on Education, American Council of Learned Societies, Association of Graduate Schools, Council of Graduate Schools, Committee on Institutional Cooperation, and International Association of Universities. The University has been accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools, 30 North LaSalle Street, Chicago, Illinois 60602-2504, (312)263-0456, www.ncahigherlearningcommission.org. Some individual programs, schools, and colleges have been recognized by the accrediting agencies in their respective fields. For a list, visit www.opb.msu.edu, select "Strategic Planning" and then "Agencies that Accredit MSU."

Transcript Validation and Authenticity

A transcript is official when it bears the signature of the University Registrar and the University seal in black ink, is obtained directly from the Office of the Registrar at Michigan State University, and is received by the person for whom it is intended. All paper-copy transcripts will be printed with black ink on paper with a green background which repeats "MICHIGAN STATE UNIVERSITY" over the entire page.

Calendar

The University offers instruction throughout the year during the fall semester, spring semester and summer sessions. Academic calendars are available at www.reg.msu.edu.

Credits

Effective Fall 1992 courses at Michigan State University are offered on a semester basis. One credit is equivalent to one instructor-student contact hour per week per semester plus two hours of study per contact hour; OR two hours of laboratory contact hours per week per semester, plus one additional hour spent in report writing and study; or other combinations of contact and study hours which constitute an equivalent of these experiences. Prior to Fall 1992 courses at Michigan State University were offered on a quarter basis.

To convert to quarter credits, the semester credits should be multiplied by 3/2.

Course Numbering System

001-099 – Non-Credit and Institute of Agricultural Technology Courses
100-299 – Undergraduate Courses
300-499 – Advanced Undergraduate Courses
500-599 – Graduate Courses prior to 1960
500-699 – Graduate – Professional Courses
800-899 – Graduate Courses
900-999 – Advanced Graduate Courses

Honors

An "H" in the Honors column indicates an honors course, honors section of a course, or the student took a non-honors course as honors. The latter indicates additional work was completed beyond normal requirements.

Grading System

The minimum cumulative grade-point average required for graduation is a 2.0 for undergraduate students and 3.0 for graduate students.

The Numerical System: 4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 – Credit is awarded for the following minimum levels – 1.0 for undergraduate students and 2.0 for graduate students. However, all grades are counted in the calculation of the grade-point average.

The Credit-No Credit System: CR-CREDIT – Credit was granted and represents a level of performance equivalent to or above the grade-point average required for graduation. NC-NO CREDIT – No credit was granted and represents a level of performance below the grade-point average required for graduation.

The Pass-No Grade System: P-PASS – Credit was granted and the student achieved a level of performance judged to be satisfactory by the instructor. N-NO GRADE – No credit was granted and the student did not achieve a level of performance judged satisfactory by the instructor.

Other Symbols Used: W-WITHDREW; V-VISITOR; U–UNFINISHED, I-INCOMPLETE; DF-DEFERRED; ET-EXTENSION; NGR-NO GRADE REPORTED; CP-CONDITIONAL PASS; & LDR-LATE DROP.

Grading Systems prior to Fall 1988: Please visit www.reg.msu.edu/transcripts.

Grade Point Average (GPA)

To compute the grade-point average for a semester, multiply the numerical grade by the number of credits for the course to obtain the total grade points. Then divide the total grade points for the semester by the total credits for the semester.

The minimum grade-point average required for graduation is 2.0 for undergraduate students and 3.0 for graduate students.

Courses in which P, I, N, DF, W, ET, CP, CR, NC, U or V have been received do not affect the grade-point average.

Grade Point systems prior to Summer 1972: Please visit www.reg.msu.edu/transcripts.

Repeated Courses

A course repeated is indicated in one of two ways:

1. By an R (Repeat) to the right of the "Descriptive Title", or
2. by an R (Repeat) in the SR column. In this case, you will also see an S (Superseded) in the SR column indicating the course being repeated.

For both formats term credit and grade-point average (GPA) totals are not adjusted for repeats in the term of the superseded course. The summary totals for the level of the student are adjusted to include only the last entry.

Withdrawal

A withdrawal from the University occurs when a student drops all courses within a semester. A student may voluntarily withdraw from the University prior to the end of the twelfth week of a semester or within the first 6/7 of the duration of the student's enrollment in a non-standard term of instruction (calculated in weekdays). Withdrawal is not permitted after these deadlines.

Courses in which the student is enrolled are deleted from the official record if the official voluntary withdrawal is before the middle of the term of instruction. If the official voluntary withdrawal is after the middle of the term of instruction, symbols are assigned by instructors to courses in which the student was enrolled as follows: W (no grade) to indicate passing or no basis for grade regardless of the grading system under which the student is enrolled, N to indicate failing in a course authorized for P-N grading, or 0.0 to indicate failing in a course authorized for numeric grading.

Michigan State University

College of Osteopathic Medicine

Upon the nomination of the Faculty and the Dean has conferred upon

Brittany Victoria Denny

the Degree of

Doctor of Osteopathic Medicine

Given under the Seal of the University at East Lansing in the State of Michigan on this third day of May in the year Two Thousand and Thirteen.

Robin L Millette
Exp. Dec 22. 2015

Chairperson of the Board of Trustees

President of the University

SEAL VERIFIED

THIS IS TO CERTIFY THIS IS A TRUE COPY

Patricia Gneiting

PATRICIA GNEITING, ASSISTANT REGISTRAR

SIGNED BEFORE ME IN INGHAM COUNTY, MI,
ON APRIL 20, 2017

Angela M Penner

ANGELA M. PENNER
NOTARY PUBLIC - STATE OF MICHIGAN
COUNTY OF CLINTON
My Commission Expires July 28, 2022
Acting in the County of Ingham

SEAL
VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

Federation of STATE MEDICAL BOARDS

Postgraduate Training

Accreditation ID: **126199**

Institution: **Mercy St Vincent MC**

Location: Toledo, OH
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Mercy St Vincent MC
Specialty: Obstetrics & Gynecology
Address: Toledo, OH

Attention: **Program Director**
Affiliated University: OUHCOM

Verification For:

Name: Brittany Victoria Denny
DOB: 07/07/1986
Individual's Name on Record (If different from above): _____

Program Participation:

Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1-3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics & Gynecology
From: 7/1/13 To: 6/30/14
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☒ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 4
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics & Gynecology
From: 7/1/16 To: Anticipated 6/30/17
Successfully Completed?: ☐ Yes ☐ No ☒ In Progress
Accredited by: ☐ ACGME ☒ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

ELECTRONIC SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☒ No
2. Was this individual ever placed on probation?	☐ Yes	☒ No
3. Was this individual ever disciplined or placed under investigation?	☐ Yes	☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☒ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Mitchell G. Greenbaum, DO Signature: M. G.
Title: Program Director Date of Signature: 4-21-17
Tel: 419 251 6522 Fax: 419 251 6849 E-Mail: babydoc444@gmail.com

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Denny, Brittany Victoria
Accreditation ID:	126199
Institution:	Mercy St Vincent MC
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2013 - 6/30/2017 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Denny, Brittany Victoria

Licensure / Examinations

Exam: NBOME - Comlex
Level 1

Exam: NBOME - Comlex
Level 2 CE

Exam: NBOME - Comlex
Level 2 PE

Exam: NBOME - Comlex
Level 3

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION - USA

Official Transcript

Federation Credentials Verification Svcs
Federation Place
400 Fuller Wiser Rd., Ste. 300
Euless, TX 76039-3855

Examinee: Denny, Brittany Victoria
NBOME ID: 998303 **Date of Birth:** 07/07/1986

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	24-Jun-2011	Pass	515	400	--		
Level 2 Cognitive Evaluation (CE)							
	23-Jul-2012	Pass	627	400	--		
Level 2 Performance Evaluation (PE)							
	08-May-2012	Pass	Not Applicable		Not Applicable		
Level 3							
	12-May-2014	Pass	693	350	--		

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: April 10, 2017

1124133910949220

-- please see reverse for information and description of notes -- v3.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

302 387 931

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:5/2/2017

PRACTITIONER INFORMATION

Name:	Brittany Victoria Denny
Alternate Name(s):	Brittany Victoria Slaughter
DOB:	7/7/1986
Medical School:	Michigan State University College of Osteopathic Medicine East Lansing, Michigan, UNITED STATES
Year of Grad:	2013
Degree Type:	DO

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:5/2/2017
Practitioner Name:	Brittany Victoria Denny	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

This message is automatically generated based upon the recent activity on your license at the State Medical Board of Ohio.

Please do not reply to this email

Dear Brittany Denny,

This email has been generated to provide notice that you have been issued a license by the State Medical Board of Ohio.

Wall certificates are mailed within five business days of licensure, to ensure receipt of your certificate please review the address below. If your address has changed it may be updated online at https://elicense.ohio.gov.

25400 Fort Meigs Rd Apt 17, Perrysburg, OH 43551, OH, 43551

For your convenience, your license information is listed below and on the attached document.

License Number: 34.012939
License Type: Doctor of Osteopathic Medicine (DO)
Effective Date: 6/20/2017
Expiration Date: 4/1/2019

If you have questions concerning this notification, please contact the Board via email at med.license@med.ohio.gov.

Sincerely,

State Medical Board of Ohio

Submission Date and Time: 1/10/2019 6:44 AM

License Renewal Application

License Type - Doctor of Osteopathic Medicine (DO)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

Title
Dr.
First Name
Brittany
Middle Name
Victoria
Last Name
Denny
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
7/7/1986
Email Address
brittanyvictoria77@gmail.com
Phone Number
7343478185
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Yes, Mexican, Mexican American, Chicano/a
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if not applicable leave blank
1952642662
Enter home US zip-code. Enter NA if unavailable
48182

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
Millersburg

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

25400 Fort Meigs Rd Apt 17
Perrysburg
OH
43551
null

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

25400 Fort Meigs Rd Apt 17
Perrysburg
OH

43551
null

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Osteopathic Association (AOA)
Medical Speciality - Obstetrics & Gynecologic Surgery
Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position

that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Sylvania OBGYN
Practice Settings - Office/Clinic - Multi Specialty Group
Street Address - 5308 Harroun Road, Suite 175
City - Sylvania
State - OH
Zip Code - 43560
Major Area of Focus or Specialty - Anesthesiology (AOA)
Total Hours Worked at this practice site, per Week - 61

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 85
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 15
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been

subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?

Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - Center for Health Services, 2150 Central Ave, Toledo, OH, 43606, Clinic Sylvania OBGYN, 5308 Harroun Rd, Sylvania, OH, 43560

Question - Primary DEA Number
Answer - FD6902553

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 1/10/2019 6:44 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Brittany Denny
Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Submission Date and Time: 3/8/2021 1:36 PM

License Renewal Application

License Type - Doctor of Osteopathic Medicine (DO)

License Number - 34.012939

License Renewal Number - LR-004032289

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Brittany
Middle Name
Victoria
Last Name
Denny
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
7/7/1986
Email Address
brittanyvictoria77@gmail.com
Phone Number
7343478185
Other Phone Number
No Response
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Yes, Mexican, Mexican American, Chicano/a
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language

No Response
Individual National Provider Identifier - if N/A enter all zeroes
1952642662
Enter home US zip-code. Enter NA if unavailable
48144

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
Millersburg

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state’s capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is
Are you currently employed outside of USA?
No

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

25400 Fort Meigs Rd Apt 17
Perrysburg
OH
43551
null

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

25400 Fort Meigs Rd Apt 17
Perrysburg
OH
43551
null

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Osteopathic Association (AOA)
Medical Speciality - Obstetrics & Gynecologic Surgery

Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Cleveland Clinic
Practice Settings - Hospital - Inpatient
Street Address - 18101 Lorain Ave
City - Cleveland
State - OH
Zip Code - 44111
Major Area of Focus or Specialty - Obstetrics & Gynecology (AOA)
Total Hours Worked at this practice site, per Week - 40

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 100
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Contractual
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - I don’t know

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - Yes

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

Question - Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services? An affirmative answer to this question provides notice to the board that your residential and familial information is exempt from disclosure under Ohio's public records laws. Failure to self-identify may result in the board releasing such

information in response to public records requests. In the event that your answer to this question changes before your next license renewal, you should immediately notify the board.
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - xd6902553

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board’s rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

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Consent to Electronic Signature - **Consented**
Date/Time Stamp - 3/8/2021 1:36 PM
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