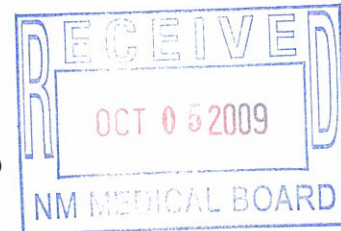


RH 11/20/09
\$434.00
cc



The New Mexico Statewide Application
for Physician/Practitioner Appointment®

Physician (MD) Application
(USING HSC)

Date of Application: Sept. 29, 2009

Fees: \$320.00 To HSC
\$434.00 to NM Medical Board
(Application Fee \$400.00 & Background Check \$34.00)

Demographics

Name	<u>Sella</u>	<u>Shelley</u>	
	Last	First	Middle

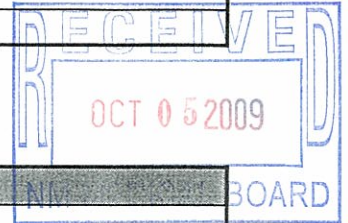
Other Names Used

Will you be applying by endorsement Yes No endorse
(See page 2 of the application instructions for requirements)

Gender	M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Place of Birth	<u>Israel</u>	Citizenship	<u>U.S.</u>
Immigration Status	<u>N/A</u>		INS Certification #		
*Social Security Number			Date of Birth	<u>[REDACTED]</u>	<u>1957</u>
*NM Tax ID# (if applicable)			Pending	<input type="checkbox"/>	
*Fed. Tax ID# (if applicable)			Pending	<input type="checkbox"/>	
Current Practice Name	<u>Planned Parenthood Shasta-Diablo</u>				
Practice Limited to: (Clinical Specialty)	<u>Obstetrics + Gynecology</u>				
Street	<u>2185 Pacheco St.</u>				
City	<u>Concord</u>	State	<u>CA</u>	Zip Code	<u>94520</u>
Telephone Number	<u>(925) 676-0505</u>	Facsimile	<u>925-676-2814</u>		
*Office Manager or Contact Person:					
Foreign Languages (spoken fluently by practitioner)	<u>Spanish, Hebrew</u>				
Foreign Languages (spoken fluently at Practice)	<u>Spanish</u>				
*E-Mail Address (confidential)	<u>[REDACTED]@hotmail</u>				
*Current Mailing Address (if different from above -confidential unless no practice address indicated)					
*Street					
*City		*State	<u>CA</u>	*Zip Code	<u>94609</u>
Telephone Number		Facsimile	<u>N/A</u>		
What are your immediate or future Practice Plans in New Mexico?	<u>I plan to work at Southwestern Women's Options.</u>				
Home Address (Required)	*Telephone Number				
Street					
*City		*State	<u>CA</u>	*Zip	<u>94609</u>

*Information Confidential

Practice Associates in NM (If Applicable)		Call Coverage in NM (If Applicable)	
Other Practice Locations (If Applicable)			
Practice Name			
Street			
City		State	Zip Code
Telephone Number		Facsimile	
Answering Service		Effective Date	



Education (Please attach a separate sheet, if necessary.)

Undergraduate Education			
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
Professional / Medical Education			
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
Graduate Education			
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
College or University			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Graduation Date
Internship/ Residency/ Fellowship			
Institution Name			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Field
Institution Name			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Field
Institution Name			
City	State/Country	Zip Code:	
Dates Attended	From:	To:	Field

SW [Signature]

Work History Please list all previous practice experience for the last 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved and attach copy of discharge or separation documents. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

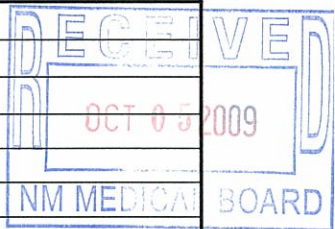
Location	Planned Parenthood Shasta- Diablo	From	11/2000	To	present
Street	2185 Pacheco St	Phone Number	(925) 676-0505		
City	Concord	State	CA	Zip Code	94520
Type of Practice	Family Planning / Abortion	Contact Person	Phyllis Schoenwald		
Type of Discharge		Rank Achieved	MD		
Location	Pregnancy Consultation Center	From	9/04	To	present
Street	5301 F St,	Phone Number	(916) 446-0222		
City	Sacramento	State	CA	Zip Code	95819
Type of Practice	Family Planning / Abortion	Contact Person	Cara Keefer		
Type of Discharge		Rank Achieved	MD		
Location	Women's Health Care Services	From	6/02	To	5/09
Street	5107 E. Kellogg	Phone Number			
City	Wichita	State	KS	Zip Code	67218
Type of Practice	Abortion services	Contact Person	Juan Armentrout		
Type of Discharge	clinic closed due to assassination	Rank Achieved	associate physician		
Location	Women's Health Special MD	From	07/01	To	3/02
Street	1469 Humboldt St	Phone Number	(530) 891-1917		
City	Chico	State	CA	Zip Code	95928
Type of Practice	Family Planning / Abortion	Contact Person	Penny Bertsch		
Type of Discharge		Rank Achieved			

see
attach

Hospital and Health Facility Affiliation History (other than postgraduate training) N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	From:			To:	
Type of Appointment					
Privileges Assigned					
(2) Facility Name	Keiser Foundation Hospital				
Street	280 W. MacArthur Blvd.				
City	Oakland	State	CA	Zip Code	94611
Telephone Number	(510) 752-1000		Facsimile	510-752-1671	
Appointment Dates	From:	July 1, 1993	To:	March 11, 2001	
Type of Appointment	courtesy				
Privileges Assigned	Obstetrics + Gynecology				
(3) Facility Name	Alta Bates Medical Center				
Street	2450 Ashby Ave				
City	Berkeley	State	CA	Zip Code	94705
Telephone Number	(510) 204-1221		Facsimile	510-204-1221	
Appointment Dates	From:	May 8, 1997	To:	June 6, 2001	
Type of Appointment	courtesy				
Privileges Assigned	Obstetrics and Gynecology				



see
attach

Applicant Name Stelley Selk Date 9/29/09

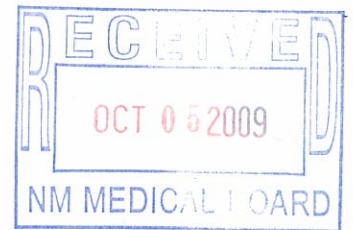
WORK HISTORY cont.

Planned Parenthood Mar Monte from 01/2002 – 2004
1692 The Alameda
San Jose, CA 95126
(408) 795-3600
Family Planning/Abortion
Contact: Dick Fischer, MD

Planned Parenthood Golden Gate from 09/2000-02/2002
815 Eddy St.
San Francisco, CA 94109
(415) 441-7858
Family Planning/ Abortion
Contact: Dick Fischer, MD

Kaiser Permanente Medical Group from 07/1993-03/2001
280 W. MacArthur Blvd.
Oakland, CA 94609
(510) 752-1000
Obstetrics and Gynecology
Contact: Lesley Levine, MD

La Clinica de La Raza from 04/1994-08/1996
1505 Fruitvale
Oakland, CA 94623
(510) 535-4000
Obstetrics and Gynecology
Contact: Susan Sykes, MD



Stelle, Sella 9/22/09

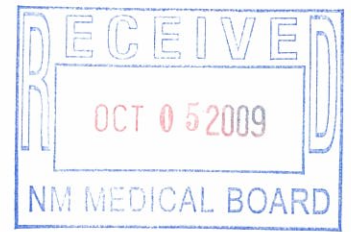
PAST HOSPITAL PRIVILEGES CONT.

Summit Medical Center
350 Hawthorne Ave.
Oakland, CA 94609
(510) 869-6565

Fax: 510-869-6107

Appointment from May 26, 1994 to March 25, 1997

Privileges: Obstetrics and Gynecology



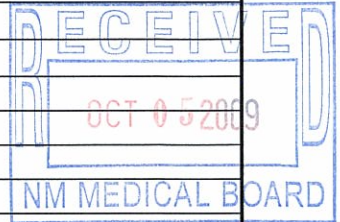
I do not currently have hospital privileges. Planned Parenthood patients are referred to the Emergency Room of a local hospital if indicated.

In my other position at Pregnancy Consultation Center, patients are admitted under the care of Dr. Mark Maltzer at Sutter General Hospital in Sacramento, California.

Hosp
Affils.

Shelley Sella 9/29/09

(4) Facility Name				
Street				
City	State	Zip Code		
Telephone Number	Facsimile			
Appointment Dates	From:	To:		
Type of Appointment				
Privileges Assigned				
(5) Facility Name				
Street				
City	State	Zip Code		
Telephone Number	Facsimile			
Appointment Dates	From:	To:		
Type of Appointment				
Privileges Assigned				
(6) Facility Name				
Street				
City	State	Zip Code		
Telephone Number	Facsimile			
Appointment Dates	From:	To:		
Type of Appointment				
Privileges Assigned				
(7) Facility Name				
Street				
City	State	ZIP Code		
Telephone Number	Facsimile			
Appointment Dates	From:	To:		
Type of Appointment				
Privileges Assigned				
(8) Facility Name				
Street				
City	State	Zip Code		
Telephone Number	Facsimile			
Appointment Dates	From:	To:		
Type of Appointment				
Privileges Assigned				



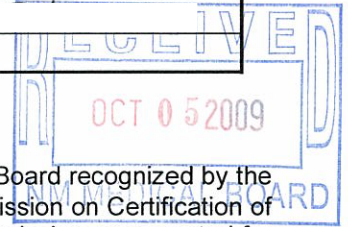
Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title Jeff Waldman MD				
Address 2185 Pacheco St.				
City	State	Zip Code		
Telephone Number	Facsimile			
(2) Name and Title Mark Maltzer, MD				
Address 5301 F St.				
City	State	Zip Code		
Telephone Number	Facsimile			
(3) Name and Title Susan Robinson, MD				
Address 2471 Cielo Vista Rd				
City	State	Zip Code		
Telephone Number	Facsimile			

Applicant Name Slob Slob Date 9/29/09
Page 4

Licensure-Registration-Certification Information

ECFMG Number (if applicable)				
State Professional License/Certification Number				A45595
State	CA	Issue Date	12/08/1988	Expiration Date 8/31/2010 Pending <input type="checkbox"/>
All Other State License Numbers (regardless of status - attach separate list if necessary.)				
State	Number	Issue Year	Expiration Date	
Kansas	04-29603	2002	June 30, 2010	
Wisconsin	28642	1987	Nov. 1, 1989	
New York	171295	1987	Dec 31, 1988	
*Federal Drug Enforcement Admin. (DEA) Registration				N/A <input type="checkbox"/>
Number		Exp. Date	2/29/12	Pending <input type="checkbox"/>
*State Controlled Substance Registration (CSR)				N/A <input checked="" type="checkbox"/>
Number		State	Exp. Date	Pending <input type="checkbox"/>
*Medicare Unique Physician Identification Number (UPIN)				N/A
Pending <input type="checkbox"/>				
*State Medicaid Provider Number				N/A
Pending <input type="checkbox"/>				
*National Provider Identification Number				
Pending <input type="checkbox"/>				



Specialty Board Certifications N/A

Are you Board Certified? Yes No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

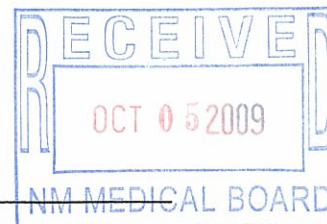
Certified/Recertified by the:			
1.	American Board of Obstetrics and Gynecology		
Date Certified	11/7/97	Date Last Recertified	2008
Expiration Date	12/31/2009		
2.			
Date Certified		Date Last Recertified	
Expiration Date			
3.			
Date Certified		Date Last Recertified	
Expiration Date			
Accepted for Examination by the:			
Until (expiration date)		If not accepted, have you made application?	Yes No
Certified/Recertified by the Subspecialty Board of			
1.			
Date Certified		Date Last Recertified	
Expiration Date			
2.			
Date Certified		Date Last Recertified	
Expiration Date			
Accepted for Examination by the Subspecialty Board of			

See attach

Professional Liability Insurance (confidential information)

Do you have current liability insurance? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Current Carrier	National Union Fire Insurance	Current	<input checked="" type="checkbox"/> Pending <input type="checkbox"/>
Address	1166 Ave of the Americas, New York NY 10036		
Dates Insured	From Nov 2000	To Current	Policy # [REDACTED]
Coverage Limits	[REDACTED]		

Applicant Name Stella Sella Date 9/29/09



Licensing Exam: Please check all that apply:

State Board Exam (Prior to 1973) Which state? _____ Date(s) passed? _____
 FLEX **LMCC** **National Board (NBME)** **USMLE**
Part/Step 1 Date Passed _____ Part/Step 2 Date Passed 5-2006 Part/Step 3 Date Passed _____
Month/Year Month/Year Month/Year

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Have you ever been named as a defendant in any criminal proceedings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Are any currently held licenses pending investigation or being challenged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Applicant Name _____
Page 6

[Signature]

Date

9/29/09

<p>15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information on the attached Malpractice History form for each case:</p> <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. 	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>
<p>16. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?</p>		
<p>17. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.</p>		
<p>18. Have you ever, for any reason:</p> <p>a) Resigned from a medical school or postgraduate training (PGT) program?</p> <p>b) Withdrawn from a medical school or postgraduate training program?</p> <p>c) Been suspended, dismissed, or expelled from a medical school or PGT program?</p> <p>d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?</p> <p>e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>



If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.



Applicant Name Stella Sella Date 9/29/2009
 Page 7

APPLICANT'S OATH

I, Shelley Sella, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.



Shelley Sella Sept. 29, 2009
Applicant Signature Date



*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Shelley Sella Date 9/29/09
Page 8

Professional Practice Question No. 8; Have you ever been subject to an investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?

Operation Rescue, based in Wichita, Kansas filed three complaints against me to the Kansas State Board of Healing Arts. The Board is required by statute to investigate complaints that allege a violation of the Healing Arts Act.

Case No. 08-00176 was initiated after a complaint by _____, the president of Operation Rescue alleging that I did not see or speak to a patient prior to the start of an abortion procedure. The Disciplinary Panel found that a hand written note for surgical procedures was not legible and insufficient. It asked that I complete a record keeping course and start dictating operative procedures. I complied with the Panel's recommendation and the case is closed.

Case No. 08-00604 was initiated after a complaint by _____ a senior policy advisor of Operation Rescue alleging unprofessional conduct. The Disciplinary Panel found that the evidence was insufficient to support a violation of the Healing Arts Act. The case is closed.

Case No. 09-00184 was initiated after a complaint by _____ regarding the treatment and care of a patient. The Medicine and Surgery Review Committee found that the care provided met the applicable standard of care. The case is closed.



Shellen Sells 9/29/09



Malpractice History



Provider Name: Shelley Sells

Please DUPLICATE this form and complete for EACH case.

1. Patient Name:

2. Diagnosis:

Spontaneous uterine rupture

3. Your involvement in the case, i.e... Attending, Consulting, Etc.:

Attending

4. Allegation(s):

Negligent management of labor and delivery leading to spontaneous rupture and infant quadriplegia.

5. Clinical Case Summary:

30 year old multiparous woman had a spontaneous uterine rupture resulting in neonatal hypoxic ischemic encephalopathy in her son.

6. Patient Outcome: Patient died in infancy of sepsis, aspiration pneumonia

7. Other pertinent details:

Other parties named: Kaiser Foundation Health Plan inc, Permanente Medical Group, Kaiser Foundation Hospital

8. Date of incident: Mk 31, 2000 Date filed: Oct. 25, 2000

Date closed: Feb. 27, 2002

9. Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:

Settled

10. Settlement amount paid on your behalf (if any):

\$500,000 on behalf of the Permanente Medical

11. Professional liability insurer involved:

a. Name of Insurer: Kaiser Permanente Medical Care Group

b. Address of Insurer: One Kaiser Plaza, Oakland, CA

12. Defense attorney: Botwick and Associates 94612

Shelley Sells
Signature

9/29/09
Date



Malpractice History

Provider Name: Shelley Sells

Please DUPLICATE this form and complete for EACH case.

1. Patient Name: _____

2. Diagnosis: _____

Sixteen weeks undesired pregnancy

3. Your involvement in the case, i.e... Attending, Consulting, Etc.: _____

Attending

4. Allegation(s): _____

Negligent performance of an elective D+E leading to a perforated uterus and associated complications.

5. Clinical Case Summary: _____

28 year old sustained a perforated uterus during an elective D+E.

6. Patient Outcome: good

7. Other pertinent details: _____

Other parties named: Kaiser Foundation Health Plan, Inc., Permanente Medical Group, Kaiser Foundation Hospital

8. Date of incident: Dec. 6, 1994 Date filed: Nov. 30, 1995

Date closed: Sept 20, 1996

9. Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other: _____

Settled

10. Settlement amount paid on your behalf (if any): _____

\$25000 on behalf of The Permanente Group

11. Professional liability insurer involved: _____

a. Name of Insurer: Kaiser Permanente Medical Care Program

b. Address of Insurer: One Kaiser Plaza Oakland CA

12. Defense attorney: Harding Cook, Lopez, Engel

and Berger 94612

Shelley Sells

Signature

9/29/2009

Date

ABO+
C

RECERTIFIED
2007
Through December 31 2008

First in Women's Health
Shelley Sella, MD
930269

RECEIVED
OCT 05 2009
NM MEDICAL BOARD

ABO+
C

ANNUAL BOARD CERTIFICATION
2008
Voluntarily

First in Women's Health
Shelley Sella, MD
930269



DIPLOMATE

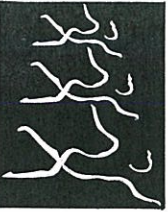
American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

Obstetrics and Gynecology

Shelley Sella, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK,
HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS
REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.,
AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD
FROM NOVEMBER, 1997 THROUGH DECEMBER, 2007
NOVEMBER 7, 1997



American Board of Obstetrics & Gynecology

Robert C. Caplan
President

Richard D. Sibara
Debra Weiss

Justin A. Strubbe

Debra Bergowitz

DIPLOMATE NO. 930269

Michael D. ...
Executive Director

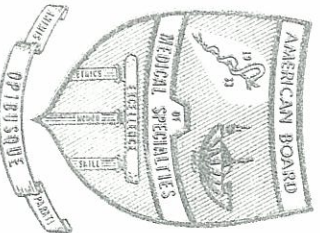
Michael S. ...

Frank ...

Michael S. ...

David K. ...

Raymond ...
Robert D. ...
Shirley ...
Walter C. ...
Ronald S. ...
James A. ...



Applicant's Attestation

I, Shelley Sellg, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws if applicable of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Shelley Sellg
Signature

Sept. 29 2009
Date

Note: A cover letter should accompany this form identifying the requesting organization so that applicants can return the form to the appropriate organization.

All applicants have the right to be informed of their application status. Application status inquiries may be directed to either HSC or the appropriate health care organization.

(This attestation may be replaced by the healthcare organization's own attestation.)

This form may be downloaded from any of the following web-sites:

- www.nmhsc.com
- www.nmms.org
- www.gamamed.org/gama



HSC

P.O. Box 92200
Albuquerque, NM 87199-2200
505-343-0070
Facsimile 505-346-0288
Office Hours M-F 800 a.m. - 500 p.m.
cvs@nmhsc.com
www.nmhsc.com

Hospital Services Corporation, a subsidiary of the New Mexico Hospitals and Health Systems Association, maintains this form, as well as a users' mailing list, to distribute any subsequent revisions. If you have any questions about this form or if you would like to be included on the users' list, please contact one of our credentials analysts at 1-800-577-2121 or 505- 343-0070, or by e-mail to cvs@nmhsc.com.

Applicants using HSC for source documents must complete this form.

CREDENTIALS VERIFICATION SERVICE

**DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")**

Authority to Release: I have applied to participate as a provider for the New Mexico
Medical Board

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated the Hospital Services Corporation's Credentials Verification Service ("HSC/CVS") as their agent. I consent to complete disclosure by the recipient of this release to HSC/CVS of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC/CVS all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC/CVS, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquires concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC/CVS to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon New Mexico or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider.

This Release does not authorize HSC/CVS to disclose information about my qualifications to any claimant. If a claimant requests information from HSC/CVS about me or if a subpoena duces tecum is served upon HSC/CVS seeking information about me, which is in HSC/CVS' possession, I understand I will be notified immediately. If I direct HSC/CVS to resist the subpoena, I hereby agree to indemnify and hold harmless HSC/CVS, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the New Mexico Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC's Credentialing Verification Service and is received within five years of its date.

The certain definitions used in this Release and set forth on its reverse side are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to the HSC/CVS. PHOTOCOPY BOTH PAGES OF THIS FORM.

Shelby Sells MD
Applicant Signature

Shelby Sells
Printed Name

Sept. 29, 2009
Date

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

“Health Care Entity” is the Health Care Entity on the front of this form.

The “Health Care Entity’s Authorized Representatives” include any management or quality assurance companies hired by the Health Care Entity or the HSC/CVS; the Health Care Entity’s Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including the HSC/CVS; and the Health Care Entity’s attorneys and insurers.

“Credentials and Privileges” means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

“Credentialing Verification Service” is the service operated by the Hospital Services Corporation. HSC/CVS may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC/CVS’ system. The person providing this Release that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

“Claimant” means any person guardian, or personal representative who is asserting an administrative or legal claims against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

“Medical Staff or Provider Panel” is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

“Third Parties who have a need to know,” include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations (“IPAs”), Managed Service Organizations (“MSOs”), Physician Hospital Organizations (“PHOs”), Preferred Provider Organizations (“PPOs”), Health Maintenance Organizations (“HMOs”), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity’s Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

P:\WP\MSAS\RELM MH.DOC
REVISED APRIL, 1996



AMA Physician Profile

Name and Mailing Address:

SHELLEY SELLA MD

Primary Office Address:

PLANNED PARENTHOOD
2185 PACHECO ST
CONCORD CA 94520-2309

Phone: 1-925-676-0505

Birthdate: [REDACTED] 1957

Birthplace: TEL-AVIV ISR

Physician's Major Professional Activity: HOSPITAL BASED FULL-TIME PHYSICIAN STAFF

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

————— All Information from this Point Forward is Provided by the Primary Source —————

Current and/or Historical Medical School:

TEL AVIV UNIV, SACKLER SCH OF MED, TEL AVIV-YAFO, ISRAEL

Degree Awarded: Yes

Degree Year: 1986



AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: ST MARY'S HOSP MED CTR **State:** WISCONSIN
Specialty : FAMILY MEDICINE 07/1986 - 06/1987
 (VERIFIED)

Institution: KAISER PERMANENTE MED CTR **State:** CALIFORNIA
Specialty : OBSTETRICS & GYNECOLOGY 07/1989 - 06/1993
 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

<u>Jurisdiction</u>	<u>MD/DO</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Status</u>	<u>License Type</u>	<u>Last Reported</u>
KANSAS	MD	04/06/2002	06/30/2010	ACTIVE	UNLIMITED	10/01/2009
CALIFORNIA	MD	12/08/1988	08/31/2010	ACTIVE	UNLIMITED	09/16/2009
NEW YORK	MD	07/30/1987	NOT RPTD	INACTIVE	UNLIMITED	01/11/2008
WISCONSIN	MD	07/01/1987	11/01/1989	INACTIVE	UNLIMITED	09/10/2009

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certification:

Applicant Number: 03886579

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.



AMA Physician Profile

Federal Drug Enforcement Administration:

* Only the last three characters of active DEA number(s) are displayed.

<u>DEA Number *</u>	<u>Schedule</u>	<u>Expiration Date</u>	<u>Last Reported</u>
		02/29/2012	09/10/2009

Address: 4

		02/28/2010	09/10/2009
--	--	------------	------------

Address: Planned Parenthood, 2185 Pacheco St, Concord, CA 94520-2309

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Certificate: OBSTETRICS & GYNECOLOGY

Certificate Type: GENERAL

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Occurrence</u>	<u>Last Reported</u>
TIME LIMITED	12/31/2008	12/31/2009	RE-CERT	09/10/2009
TIME LIMITED	12/31/2007	12/31/2009	RE-CERT	09/10/2009
TIME LIMITED	12/31/2006	12/31/2008	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/2004	12/31/2007	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/2003	12/31/2007	RE-CERT(**)	09/10/2009
TIME LIMITED	12/31/2002	12/31/2007	RE-CERT(**)	09/10/2009
TIME LIMITED	11/07/1997	12/31/2007	INITIAL(**)	09/10/2009

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

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AMA Physician Profile

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (<http://www.ama-assn.org/go/amaprofiles>) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

**The Federation of State Medical Boards
of the United States, Inc**
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

October 06, 2009

Attn: Lynn S. Hart, Executive Dir.
New Mexico Medical Board
2055 S. Pacheco, Bldg.400
Santa Fe, NM 87505

Re: Board Action Query Dated: October 06, 2009
Your Reference Number:
FSMB Batch Number: BQ1677556

The following is a report of the search results from the Board Action Data Bank as of October 06, 2009 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of October 06, 2009

Item	Name	DOB	School	Yr/Grad	Request ID
1	sella, shelley	08/08/1957	550020	0586	21440742

LICENSE HISTORY

State Board
CALIFORNIA
KANSAS
NEW YORK
WISCONSIN

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.



License Information:

The following information is maintained by the Medical Board of California.

License:	A 45595
License Type:	Physician and Surgeon Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the FLEX (Federation Licensing Exam), USMLE (United States Medical Licensing Exam) or LMCC (Licentiate of Medical Council of Canada) written examination and has been licensed less than four years in another state OR may be an International medical school graduate whose pathway to licensure was based on the above exams or approved combinations of the NBME (National Board Medical Exam), FLEX or USMLE.
Name:	SHELLEY SELLA, M.D.
Address of Record:	PLANNED PARENTHOOD SHASTA DIABLO 2185 PACHECO STREET CONCORD, CA 94520
Address of Record County:	CONTRA COSTA
License Status:	License Renewed & Current Licensee meets requirements for the practice of medicine in California.
Public Record Action(s):	No Public Record Actions available
Original Issue Date:	December 8, 1988
Expiration Date:	August 31, 2010
School Name:	TEL AVIV UNIVERSITY, SACKLER SCHOOL OF MEDICINE
Year Graduated:	1986

Physician Information:

The following information is self-reported by the licensee and has not been verified by the Board.

Public Record Action(s):

Please select the Public Record Documents tab to view the public document database. If information is posted in the Administrative/Disciplinary Actions or Administrative Citation Issued categories below, documents may be available for review. To find out what information is and is not available, please click [here](#).

Administrative/Disciplinary Action:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

No information available.

Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

No information available from this agency.

Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

No information available from this agency.

Misdemeanor Conviction:

California Business and Professions Code section 2027 (A)(7) states effective 1/1/07, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet.

No information available from this agency.

Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

No information available.

Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide health care services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

No information available from this agency.

Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

No information available from this agency.

Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the arbitration award report or any other information concerning the award.

No information available from this agency.

Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of \$30,000 or more.

No information available from this agency.

Note: "No information available from this agency" may not indicate none exists; but indicates no information has been reported to the Medical Board of California and/or that the Board is unable to post the information on the Web site by law.

Disclaimer

All information provided by the Medical Board of California on this Web page, and on its other Web pages and Internet sites, is made available to provide immediate access for the convenience of interested persons. While the Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. Neither the Board, nor any of the sources of the information, shall be responsible for any errors or omissions, or for the use or results obtained from the use of this information. Other specific cautionary notices may be included on other Web pages maintained by the Board. All access to and use of this Web page and any other Web page or Internet site of the Board is governed by the Disclaimers and Conditions for Access and Use as set forth at [California Department of Consumer Affairs' Disclaimer Information and Use Information](#).

AIM

Association of State Medical Board Executive Directors

Kansas Board of Healing Arts Search Results

Licensee Name	Shelley Sella
Profession Description	Medical Doctor (MD)
License Type	Active
License Status	Current
Specialty	21-Gynecology
License Number	0429603
Address	
City State Zip	
Phone	
School	Univ Tel Aviv Sackler Sch Med
Degree Date	05/20/1986
Birthdate	1957
Original License Date	04/06/2002
License Expiration Date	06/30/2010
Continuing Education Year	2011
No Derogatory Information on File	

This data effective 10/22/2009

**Direct questions and comments about these results to
Kansas Board of Healing Arts
235 South Topeka Blvd.
Topeka, Kansas 66603
Phone (785) 296-7413**

Return to the Kansas State Board of Healing Arts [Home Page](#)

This Board's data has been searched 11067289 times since 12/11/1997

Please read the AIM Disclaimer©Copyright 1997 2008 Nicholas Hayer



State of Wisconsin Department of Regulation & Licensing

Online Applications: Credential Lookup

[Home](#) | [About DRL](#) | [Contact Us](#) | [FAQ](#) | [Site Map](#) | [Login](#)

Wisconsin Credential Lookup

location: [DRL](#) -> [Credential Lookup](#) -> Credential Summary

Credential Summary - Details

Credential Summary for 28642-20

Name:	Sella, Shelley
Credential Type:	Medicine and Surgery (20)
Credential Number:	28642-20
Location:	SANTA CRUZ, CA
License Type:	regular
Status	credential license is not current (expired)
Eligible To Practice:	Not Eligible to Practice
First Fee Received:	NO

[Details](#)

[Requirements](#)

[Payments](#)

[Orders](#)

[Relationships](#)

Details

License current through:	11/01/1989
Granted date:	07/01/1987
Multi-state:	N
Orders:	NONE
Specialties:	FAMILY PRACTICE
Other Names:	NONE

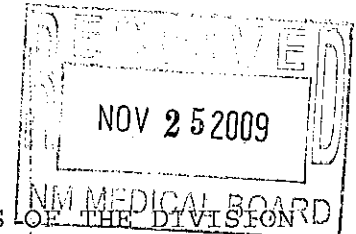
Consistent with JCAHO and NCQA standards for primary source verification.
Data on this page is refreshed hourly.

Questions?

Send an [e-mail](#), or call (608) 266-2112 between 7:45 a.m. and 2:00 p.m., Central Time.

[Contact Us](#) | [Disclaimer](#) | [Privacy Statement](#)

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234



THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, SELLA SHELLEY WAS ISSUED LICENSE/CERTIFICATE NUMBER 171295 FOR THE PRACTICE OF MEDICINE ON 07/30/87.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 08/08/57
SCHOOL ATTENDED: SACKLER SCHOOL MEDICINE
DATE OF GRADUATION: 05/20/86
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

A	DATE	EXAM#	COMPONENT 1	COMPONENT 2	FLEX	EXAMINATION
	06/86		00078	00082		

EXMS TAKEN=01

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: NO
ADDRESS: 131 E 64 STREET
REG PERIOD ENDS:
NEW YORK NY 10019-0000

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.

COMMENTS:

I MARTIN CARMODY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE IN CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE FORESAID INFORMATION IS TRUE AND CORRECT.



HSC

NOV 23 2009

110115 09

Martin Carmody

PRINCIPAL CLERK

Received:
Nov. 10. 2009 2:20PM
Nov. 10. 2009 9:44AM

Nov 10 2009 03:04pm

Fax:

Nov No. 4297:43p P. 2/2/003
No. 428! P. 2



PO Box 92200
Albuquerque, NM 87199-2200
7471 Pan American Freeway NE 87109
Phone: (505) 343-0070
Toll Free: (866) 808-0070
www.hsc.com

WORK HISTORY VERIFICATION

Re: Shelley Sella MD (37217) SSN: [redacted] DOB: [redacted] 1957
From: Planned Parenthood Shasta
2185 Pacheco St
Concord, CA 94620

- 1. Evaluation based on: Observation of Applicant Review of Credentialing/Personnel File
- 2. Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.) Contract MD / Active
- 3. Specialty or Department: Reproductive Health
- 4. Status: (Temporary, Permanent, Provisional) Contract
- 5. Dates of Membership/Employment as Reported by Practitioner: From: ___ To: ___ ("In the event the "To" date is blank, it is assumed this date to be "current").
If these dates are not correct, please provide the correct dates: From: 8/2000 To: current
- 6. Termination: Voluntary Involuntary If involuntary, provide details on a separate sheet.
- 7. Do you know of any reason why the referenced practitioner should not be licensed to practice in the State of New Mexico, including any mental or physical reason?
No Yes ___ Please provide details on a separate attached sheet.
- 8. Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished?
No Yes ___ Please provide details on a separate attached sheet.
- 9. Has your Executive Committee for any reason ever disciplined this practitioner?
No Yes ___ Please provide details on a separate attached sheet.
- 10. Has this practitioner been a member in good standing on your staff?
No ___ Yes Please provide details on a separate attached sheet.

Would Recommend Would Not Recommend Current Staff: Yes No

Comments: Dr Sella is an outstanding physician and caregiver. She has excellent clinical skills.

Phyllis Schienwald, PA
Signature
Phyllis Schienwald, PA
Print Name

11/5/09
Date
V.P. Medical Services HSC
Title
NOV 10 2009

Please return this information to the attention of:
Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200 Albuquerque, NM 87199-2200

CVS
HSC
NOV 10 2009
CVS



PO Box 92200
 Albuquerque, NM 87199-2200
 7471 Pan American Freeway NE 87109
 Phone: (505) 343-0070
 Toll free: (866) 908-0070
 www.nmhsc.com

WORK HISTORY VERIFICATION

Re: Shelley Sella MD (37217) SSN: [REDACTED] DOB: [REDACTED] 1957
 From: Pregnancy Consultation Center
 5301 F St.
 Sacramento, CA 95819

- Evaluation based on: Observation of Applicant Review of Credentialing/Personnel File
- Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.) _____
- Specialty or Department: OB/GYN
- Status: (Temporary, Permanent, Provisional) _____
- Dates of Membership/Employment as Reported by Practitioner: From: *To: ____ (*In the event the "To" date is blank, it is assumed this date to be "current").
 If these dates are not correct, please provide the correct dates: From: 9/04 To: PRESENT
- Termination: Voluntary Involuntary If involuntary, provide details on a separate sheet. N/A
- Do you know of any reason why the referenced practitioner should not be licensed to practice in the State of New Mexico, including any mental or physical reason?
 No Yes _____ Please provide details on a separate attached sheet.
- Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished?
 No Yes _____ Please provide details on a separate attached sheet.
- Has your Executive Committee for any reason ever disciplined this practitioner?
 No Yes _____ Please provide details on a separate attached sheet.
- Has this practitioner been a member in good standing on your staff?
 No _____ Yes Please provide details on a separate attached sheet.

Would Recommend Would Not Recommend Current Staff: Yes No

Comments: _____

[Signature]
 Signature
MARK MATTHEW, MD
 Print Name

11/04/09
 Date
MEDICAL DIRECTOR
 Title

Please return this information to the attention of:
 Hospital Services Corporation
 Credentials Verification Services
 P. O. Box 92200 Albuquerque, NM 87199-2200

HSC
 NOV 06 2009
CVS



PO Box 92200
Albuquerque, NM 87199-2200
7471 Pan American Freeway NE 87109
Phone: (505) 343-0070
Toll free: (866) 908-0070
www.nmhscc.com

WORK HISTORY VERIFICATION

Re: Shelley Sella MD (37217) SSN: [redacted] DOB: [redacted] 1957
From: Women's Health Care Services
5107 E. Kellogg
Wichita, KS 67218

and discussion re prior director

- Evaluation based on: Observation of Applicant Review of Credentialing/Personnel File
- Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.) staff physician / associate
- Specialty or Department: gynecology
- Status: (Temporary, Permanent, Provisional) Permanent
- Dates of Membership/Employment as Reported by Practitioner: From: *To: __ (*In the event the "To" date is blank, it is assumed this date to be "current").
If these dates are not correct, please provide the correct dates: From: 6/2002 To: 5/2009
- Termination: Voluntary Involuntary If involuntary, provide details on a separate sheet.
- Do you know of any reason why the referenced practitioner should not be licensed to practice in the State of New Mexico, including any mental or physical reason?
No Yes Please provide details on a separate attached sheet.
- Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished?
No Yes Please provide details on a separate attached sheet.
- Has your Executive Committee for any reason ever disciplined this practitioner?
No Yes Please provide details on a separate attached sheet.
- Has this practitioner been a member in good standing on your staff?
No Yes Please provide details on a separate attached sheet.

Director was assassinated, clinic was closed, all staff were terminated.

Would Recommend Would Not Recommend

clinic closed as of 5/31/2009
Current Staff: Yes No

Comments: I know the director thought very highly of this physician

Susan C. Robinson MD
Signature
SUSAN C. ROBINSON
Print Name

11/2/2009
Date
MD
Title

Please return this information to the attention of:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200 Albuquerque, NM 87199-2200

HSC
NOV 06 2009
CVS

HOSPITAL SERVICES CORP Fax:505-346-0285

Nov 9 2009 08:58am P002/002

Fax:

Nov 2 2009 03:41pm P002/003



PO Box 92200
Albuquerque, NM 87199-2200
7471 Pan American Freeway NE 87109
Phone: (505) 348-0070
Toll free: (866) 908-0070
www.hscnm.com

WORK HISTORY VERIFICATION

Re: Shelley Sella MD (37217) DOB: [redacted] 1967
From: Women's Health Care Services
5107 E. Kellogg
Wichita, KS 67218

- 1. Evaluation based on: Observation of Applicant Review of Credentialing/Personnel File
- 2. Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.) staff physician / associate
- 3. Specialty or Department: gynecology
- 4. Status: (Temporary, Permanent, Provisional) Permanent
- 5. Dates of Membership/Employment as Reported by Practitioner: From: 1/2002 To: 5/2009
*To: (in the event the "To" date is blank, it is assumed this date to be "current").
If these dates are not correct, please provide the correct dates: From: 1/2002 To: 5/2009
- 6. Termination: Voluntary Involuntary If involuntary, provide details on a separate sheet.
- 7. Do you know of any reason why the referenced practitioner should not be licensed to practice in the State of New Mexico, including any mental or physical reason?
No Yes Please provide details on a separate attached sheet.
- 8. Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished?
No Yes Please provide details on a separate attached sheet.
- 9. Has your Executive Committee for any reason ever disciplined this practitioner?
No Yes Please provide details on a separate attached sheet.
- 10. Has this practitioner been a member in good standing on your staff?
No Yes Please provide details on a separate attached sheet.

Director was assassinated

and discussion prior director

Comments: I know the director thought very highly of this physician

Susan C. Robinson
Signature
SUSAN C. ROBINSON
Print Name

11/6/2009
Date
MD
Title

Please return this information to the attention of:
Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200 Albuquerque, NM 87199-2200

sorry - #10 should be "yes" not "no"

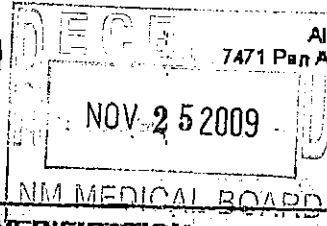
Susan C. Robinson
11/9/09

HSC
NOV 09 2009
CVS
HSC
NOV 05 2009
CVS

Fax:

Nov 23 2009 03:50pm P002/003

ATTN: Angel



PO Box 92200, Albuquerque, NM 87199-2200, 7471 Pan American Freeway NE 87109, Phone: (505) 343-0070, Toll free: (866) 908-0070, www.hmhsc.com

WORK HISTORY VERIFICATION

Re: Shelley Sella MD (37217) SSN: DO [redacted] 3/1967
From: Planned Parenthood Mar Monte
1692 The Alameda
San Jose, CA 95126

- 1. Evaluation based on: [] Observation of Applicant [X] Review of Credentialing/Personal File
2. Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.) Staff Physician
3. Specialty or Department: Abortion Services
4. Status: (Temporary, Permanent, Provisional) Contract
5. Dates of Membership/Employment as Reported by Practitioner: From: *To: (In the event the "To" date is blank, it is assumed this date to be "current").
If these dates are not correct, please provide the correct dates: From: 5/1/01 To: 7/16/05
6. Termination: [X] Voluntary [] Involuntary If involuntary, provide details on a separate sheet.
7. Do you know of any reason why the referenced practitioner should not be licensed to practice in the State of New Mexico, including any mental or physical reason?
No [X] Yes [] Please provide details on a separate attached sheet.
8. Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished?
No [X] Yes [] Please provide details on a separate attached sheet.
9. Has your Executive Committee for any reason ever disciplined this practitioner?
No [X] Yes [] Please provide details on a separate attached sheet.
10. Has this practitioner been a member in good standing on your staff?
No [] Yes [X] Please provide details on a separate attached sheet.

[] Would Recommend [] Would Not Recommend Current Staff: [] Yes [X] No

Comments:

Signature: [Handwritten Signature]
Print Name: HEIDI LIPNISKY

Date: 11/23/09
Title: Area HR manager
(408) 795-3751

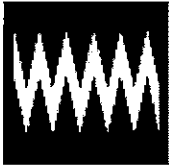
Please return this information to the attention of:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200 Albuquerque, NM 87199-2200

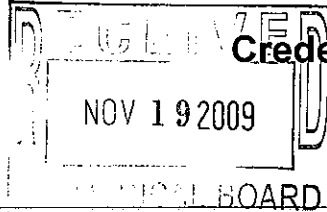
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NOV 23 2009

CVS



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Credentials Verification Services

Provider Profile

New Mexico Medical Board

Process: License by Endorsement

37217 Sella, Shelley MD

SSN: _____ DOB: [REDACTED] /1957

Start Date:	10/07/2009	Completed Date:	11/18/2009
App Rec Date:	10/07/2009	Attestation:	09/29/2009
		Next Appt:	

Organization:

Planned Parenthood Shasta-Diablo
2185 Pacheco St
Concord CA 94520
Phone: 925 676-0505 Fax: 925 676-2814
Email:
Contact:

Home Address:

NPI:
UPIN
Medicaid:
StTaxID:
FedTaxID:

*** LANGUAGES**

English
Spanish
Hebrew

*** BOARD CERTIFICATION:**

Obstetrics and Gynecology Certified: No Expiration: 12/31/2009

*** SPECIALTIES:**

N/A

*** LICENSES:**

State: CA License #: A 45595	License Type: Medicine	Expiration: 08/31/2010
Status: Current and in good standing	Issued: 12/08/1988	Verif Rec: 10/22/2009
State: KS License #: 0429603	License Type: Medicine	Expiration: 06/30/2010
Status: Current and in good standing	Issued: 04/06/2002	Verif Rec: 10/22/2009
State: WI License #: 28642-20	License Type: Medicine	Expiration: 11/01/1989
Status: Expired	Issued: 07/01/1987	Verif Rec: 10/22/2009
State: NY License #: 171295	License Type: Medicine	Expiration:
Status: Not Registered-No Exp Date on Record	Issued: 07/30/1987	Verif Rec: 11/12/2009

*** DRUG REGISTRATIONS:**

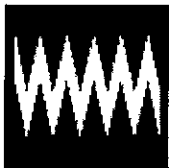
N/A
Federal Registration #: _____ Expiration: 02/29/2012

*** INSURANCE**

National Union Fire Insurance Company Policy Number:
Claims History: No Limits: [REDACTED] Expiration: N/A

*** NATIONAL PRACTITIONER DATA BANK**

N/A See Report: No



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Credentials Verification Services

Provider Profile

New Mexico Medical Board

Process: License by Endorsement

37217 Sella, Shelley MD

*** HEALTHCARE INTEGRITY AND PROTECTION DATA BANK**

N/A See Report: No

*** OIG**

N/A See Report: No

*** PROFESSIONAL PRACTICE QUESTIONS**

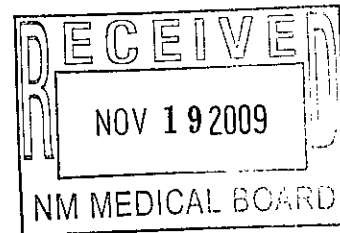
See Application: Yes

*** WORK HISTORY GAP**

See Application: No

*** PRIMARY ADMITTING FACILITY EXPLANATION**

See Application: No



*** EDUCATION:**

ECFMG NUMBER:

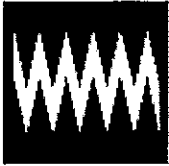
Sackler School of Medicine at Tel Aviv University		Type: Medicine
Major Doctor of Medicine	Level: Graduate	Graduation: 1986 From: 1982 To: 1986
University of WI - Madison		Type: Family Practice
Major Internship	Level: Internship	Graduation: 1987 From: 07/1986 To: 06/1987
Kaiser Foundation Hospital-Oakland		Type: Obstetrics/Gynecology
Major Residency	Level: Residency	Graduation: 1993 From: 07/1989 To: 06/1993

*** AFFILIATIONS**

Alta Bates Summit Medical Center - CA	Type: Active	From: 05/08/97 To: 06/06/01	Verif Rec: 11/9/2009
Kaiser Foundation Hospital-Oakland	Type: Resigned	From: 07/01/93 To: 03/06/01	Verif Rec: 11/12/2009
Planned Parenthood Shasta	Type: Contract	From: 08/2000 To: Present	Verif Rec: 11/10/2009
Pregnancy Consultation Center	Type: Active	From: 09/2004 To: Present	Verif Rec: 11/6/2009
Women's Health Care Services	Type: Associate/Staff	From: 06/2002 To: 05/2009	Verif Rec: 11/9/2009

*** REFERENCES**

Mark Maltzer MD	Sacramento, CA
Susan Robinson MD	Paso Robles, CA
Jeff Waldman MD	Concord, CA



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Credentials Verification Services

Provider Profile

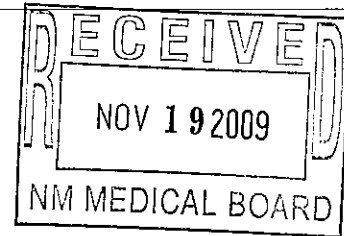
Page 3

New Mexico Medical Board

Process: License by Endorsement

37217 Sella, Shelley MD

HSC Use Only	
Completed by: <u><i>[Signature]</i></u>	Date: <u>11/18/09</u>
Reviewed by: <u><i>[Signature]</i></u>	Date: <u>11/18/09</u>
Pending items to be forwarded upon receipt:	
Comments:	





New Mexico Medical Board

2055 S Pacheco Street

Building 400

Santa Fe New Mexico 87505

Voice 505-476-7227 fax 505-476-7233 website <http://nmmb.state.nm.us/>

Triennial Renewal 7/01/2010 – 7/01/2013 Renewal Fee \$600

cc \$600.00
RECEIVED
JUN 01 2010
NM MEDICAL BOARD
11/15/07

Current Information

Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	License # <u>MD2009-0759</u>	DEA#: <u>[REDACTED]</u>
Preferred Mailing Address:	Please make corrections below.	
Shelley Sella, MD [REDACTED]	Shelley Sella MD Southwestern Women's Options 522 Lomas Blvd NE Albuquerque NM 87102	
Business Phone: 9256760505	(505) 242-7512	
Fax #:	Southwestern Women's Options	
E-Mail Address: [REDACTED]@hotmail.com	522 Lomas Blvd NE	
Business Address:	Albuquerque, NM	
2185 Pacheco St	87102	
Concord CA 94520		

NM Physician Assistant(s) currently approved and registered with the Board under your supervision:

Ø

Your license will expire July 1, 2010

I request the following change in license status: (Check only one)

- Active Status/\$600 Fee:**
- Inactive Status/\$25 Fee:** I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.
- Retired Status/No Fee:** I am retired and no longer practice medicine in New Mexico. I understand that I may not engage in the practice of medicine or write prescriptions.
- Voluntary Lapsed Status/No Fee:** I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions.

LATE RENEWALS

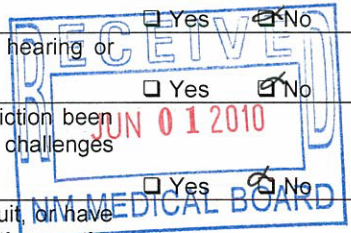
All Renewals postmarked after July 1, 2010 will require documentation of 75 CME credit hours
 Renewals postmarked after July 1, 2010 and before August 15, 2010, require payment of \$700
 Renewals postmarked after August 15, 2010 and before October 1, 2010 require payment of \$800
YOUR LICENSE WILL BE SUSPENDED AFTER OCTOBER 1, 2010 IF IT IS NOT RENEWED!

Do not submit CME documentation unless you are renewing after JULY 1, 2010.

PAYMENT INFORMATION PAGE ATTACHED

ALL QUESTIONS MUST BE ANSWERED

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians? Yes No
-
2. Since your last renewal have you been denied professional liability insurance coverage? Yes No
-
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage? Yes No
-
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? Yes No
-
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid? Yes No
-
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated). Yes No
-
7. Have you ever been named as a defendant in any criminal proceedings? Yes No
-
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome? Yes No
-
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings). Yes No
-
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency? Yes No
- b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation? Yes No
-
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation? Yes No
-
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied? Yes No
- b. Since your last renewal are any currently held licenses pending investigation or being challenged? Yes No
-
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature? Yes No
-
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items? Yes No
-
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:**
- Name, age, sex of patient/claimant.
- Date(s) and type of treatment and/or surgery, which led to the allegations against you.
 - Nature of allegations in claims/suits. Specify whether a suit was ever filed.
 - Names of other practitioners and hospital, if any, involved in claims or suit.
 - Disposition or current status of claim or suit (be specific).
 - Name of insurance carrier defending you.
 - Name of defense attorney.
- Yes No
-
16. Since your last renewal have you been reported to the National Practitioner Data Bank? Yes No
-
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?
-
18. Since your last renewal have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**
-
-
19. a. Are you currently ABMS Certified? Yes No
- b. Do you hold lifetime certification? Yes No
- c. Do you hold time limited certification? Yes No
-
20. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC? Yes No



If you answered "Yes" to any of the above questions 1-18, please provide a complete written explanation with this application. *See Attached*

- I have not completed a minimum of 75 CME hours as required by 16.10.4 NMAC and I am requesting an emergency deferral, of up to 90 days, as allowed under 16.10.4.15 NMAC. I understand I will be assessed a late renewal penalty fee of \$100 between 7/1/09-8/15/09 or \$200 between 8/16/09-10/1/09 if my CME is not completed and submitted to the Board by July 1.

SW *Sola*

May 26, 2010

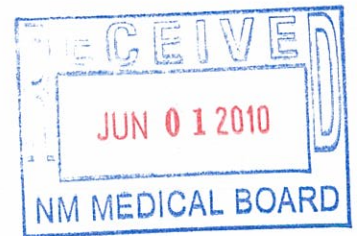
Signature of Licensee (Signature stamp is not accepted)

Date

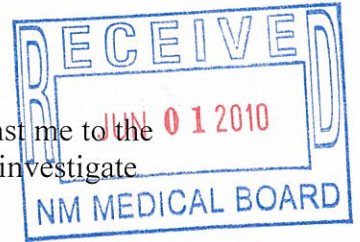
By signing above you are certifying, under penalty of perjury, that all information on this form is currently accurate.

****Your Triennial Renewal will be returned if you DO NOT:**

- Enclose correct renewal fee**
- Indicate fee to be charged to credit card**
- Sign check**
- Sign and date renewal form**
- Answer all questions and provide complete written explanations to any "yes" answers to questions 1-19**
- If you answered "NO" to question 20, and are unable to complete the required CME hours prior to the date of license expiration, you may request for an Emergency Deferral from the Board on this signature page above.**
- Submit acceptable documentation of CME (if renewing late)**
- Complete backside of renewal**



Professional Practice Question No. 8; Have you ever been subject to an investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?



Operation Rescue, based in Wichita, Kansas filed three complaints against me to the Kansas State Board of Healing Arts. The Board is required by statute to investigate complaints that allege a violation of the Healing Arts Act.

Case No. 08-00176 was initiated after a complaint by [REDACTED] the president of Operation Rescue alleging that I did not see or speak to a patient prior to the start of an abortion procedure. The Disciplinary Panel found that a hand written note for surgical procedures was not legible and insufficient. It asked that I complete a record keeping course and start dictating operative procedures. I complied with the Panel's recommendation and the case is closed.

Case No. 08-00604 was initiated after a complaint by [REDACTED], a senior policy advisor of Operation Rescue alleging unprofessional conduct. The Disciplinary Panel found that the evidence was insufficient to support a violation of the Healing Arts Act. The case is closed.

Case No. 09-00184 was initiated after a complaint by [REDACTED] regarding the treatment and care of a patient. The Medicine and Surgery Review Committee found that the care provided met the applicable standard of care. The case is closed.

Stella Solis

MD2009-0759

Medical License Renewal**Shelley Sella, License # 2009-0759****Answers to questions 8 and 13**

8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?

The New Mexico Medical Board issued a Notice of Contemplated Action in August 2012. The NCA involved a claim of gross negligence as to a single patient who underwent a third-trimester abortion and experienced a uterine rupture. The patient did not complain to the Board; instead, the complaint was generated by anti-abortion groups who found out about the case after filing a public records request for 911 calls from the clinic. Those anti-abortion activists had no actual knowledge of the facts of the patient's treatment.

I contested the NCA. A full evidentiary hearing was held on November 29 and 30, 2012. The evidence adduced at the hearing demonstrated that I was not negligent in my care of the patient, let alone grossly negligent. I followed the established standard of care in treating the patient. The notice was dismissed on February 07, 2013.

13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?

The New Mexico Medical Board issued a Notice of Contemplated Action in August 2012. Following a full evidentiary hearing, held on November 29 and 30, the notice was dismissed on February 07, 2013.

Sella, Shelley**Medical Doctor****MD2009-0759**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	06/12/2013
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/12/2013
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/12/2013
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/12/2013
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/12/2013
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/12/2013
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/12/2013
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Y	06/12/2013
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/12/2013
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	06/12/2013
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/12/2013
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/12/2013
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/12/2013
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/12/2013
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	Y	06/12/2013
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	06/12/2013
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	06/12/2013
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/12/2013
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	■	06/12/2013
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and	■	06/12/2013
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	06/12/2013
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	06/12/2013
21. If yes do you hold Lifetime Certification?	N	06/12/2013
22. If yes do you hold Time Limited Certification?	Y	06/12/2013