TEL AVIV UNIVERSITY
SACKLER FACULTY OF MEDICINE
NEW YORK STATE/AMERICAN PROGRAM

אוניברסיטת תל-אביב
הפקולטה לרפואה ע"ש סאקלר
תכנית לתלמידי מדינת ניו יורק/אמריקה

THE RECTOR OF THE UNIVERSITY AND
THE DEAN OF THE FACULTY
HEREBY CONFER ON

רקטור האוניברסיטה
ודיקן הפקולטה
מעניקים בזאת

Shelley Sella

שלי סלע

THE DEGREE OF

את התואר

DOCTOR OF MEDICINE

דוקטור לרפואה

UPON COMPLETION OF HER COURSE
OF STUDIES AND HAVING PASSED THE
EXAMINATIONS AS REQUIRED

לאחר סיימה
את חוק הלימודים
והעמידה בבחינות כנדרש

M.D.

TEL AVIV, 20, MAY 1986

תל-אביב, ביום ו' לחודש אייר תשמ"ו

RECTOR הרקטור

DEAN הדיקן

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

SHELLEY SELLA

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER	388-657-9
MEDICAL EXAMINATION	
BASIC SCIENCE	JANUARY 22, 1985
CLINICAL SCIENCE	JULY 24, 1985
ENGLISH EXAMINATION	JULY 24, 1985
VALID THROUGH	JULY, 1987

ECFMG

Stanley S. Bergen Jr. M.D.
CHAIRMAN, BOARD OF TRUSTEES

Thomas R. Mori Ph.D.
PRESIDENT, CHIEF EXECUTIVE OFFICER

Kenneth L. Cantlon M.D.
VICE PRESIDENT, CHIEF OPERATING OFFICER

DATE ISSUED
SEP 25 1985

Margaret A. Sachetti

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL
DEPARTMENT OF FAMILY MEDICINE AND PRACTICE
777 SOUTH MILLS ST. MADISON, WI 53715-1849 TELEPHONE: 608/263-4550

June 26, 1987

State of Wisconsin
Department of Regulation & Licensing
Medical Board
1400 E. Washington Avenue
Madison, Wisconsin 53703

To Whom It May Concern:

I am writing to certify that the following people satisfactorily completed their internship year in Family Practice at the University of Wisconsin-Madison Department of Family Medicine and Practice from July 1, 1986 to June 30, 1987.

Kay M. Balink, M.D.
Tracy L. Bell, M.D.
Rebecca Bull, M.D.
Terence M. Calderwood, M.D.
Kevin G. Carr, M.D.
Mark A. Josefski, M.D.
John M. Ostergaard, M.D.
Elissa J. Palmer, M.D.
Jane M. Pemberton, M.D.
Bradley S. Roter, M.D.
Shelley Sella, M.D.
Diane L. Wendland, M.D.

If you have any questions, please feel free to contact me at the above telephone number or address.

Sincerely,

Marc F. Hansen, M.D.
Director
Madison Family Practice Program
Professor
University of Wisconsin Medical School

584 (5/86)
Ch. 448 Wis Stats

STATE OF WISCONSIN
DEPARTMENT OF REGULATION & LICENSING
MEDICAL EXAMINING BOARD
P.O. BOX 8935
MADISON, WISCONSIN 53708
(608) 266-2811

CHECK FORM FOR PHYSICIANS

Exam	40.00
Temporary	
Paid	2/27/87

Shelley Sella, M.D.
1714 Helena Street
Madison, WI 53704

APPLICATION FORM	NOT APPLICABLE	COMPLETE	IS REQUIRED
PAGE ONE			
Applicable blanks completed		✓	
Pre-professional and professional education		✓	
One year of post-graduate training		✓	
All activities and practice accounted for		✓	
PAGE TWO			
Applicable blanks completed		✓	
All questions answered and relevant copies attached		✓	
PAGE THREE			
All questions answered		✓	
Affidavit of applicant, signed and notarized		✓	
Certificate of professional education complete (including signature and school seal)			✓
Certificate of Board issuing original license or FLEX scores, original certification or NATIONAL BOARD scores, original certification or LMCC certification		✓	
ENCLOSURES			
Authorization and Waiver, notarized		✓	
Notarized photo		✓	
Professional diploma, notarized		✓	
Internship certificate, notarized			✓
ECFMG certificate, notarized		✓	
Is name on all credentials the same? If not submit notarized copy of marriage certificate, divorce decree, etc.			
Machine readable application		✓	
Verification of state license(s)			
REMARKS			

MEDTXT-W

Committed to Equal Opportunity in Employment and Licensing

State of Wisconsin | DEPARTMENT OF REGULATION & LICENSING

Anthony S. Earl
Governor

Barbara Nichols
Secretary

1400 E. WASHINGTON AVENUE
P.O. Box 8935
MADISON, WISCONSIN 53708
608 266-2112

THIS PAGE MUST BE COMPLETED BY YOUR MEDICAL SCHOOL AND RETURNED TO THE WISCONSIN MEDICAL EXAMINING BOARD

CERTIFICATE OF PROFESSIONAL EDUCATION

It is hereby certified that Shelley Sella
(name of applicant)

matriculated in Sackler School of Medicine at Tel Aviv, Israel
(name of school) (location of school)

and received a diploma conferring the degree of Doctor of M.D.

dated May 20, 1986.

Sarah Himel, Registrar
(President, Secretary, Dean of Registrar)

Date March

PM:cld
MEDTXT-V

THIS FORM MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED M-1/2

AUTHORIZATION AND WAIVER

I, Shelley Sella born at Tel-Aviv Israel on August 8 1957, having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

Subscribed and sworn to before me this
23 day of February, 1987

Pamela J Luedtke
NOTARY PUBLIC
Comm. Expires: 2/18/90

Shelley Sella
Signature of Applicant

AUTHORIZATION AND WAIVER

I, Shelley Sella born at Tel-Aviv Israel on August 8 1957, having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

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NOTARY PUBLIC
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Shelley Sella
Signature of Applicant

MEDTA

STATE OF WISCONSIN
DEPARTMENT OF REGULATION & LICENSING
MEDICAL EXAMINING BOARD
P.O. Box 8935
Madison, Wisconsin 53708

APPLICATION FOR LICENSE TO PRACTICE MEDICINE & SURGERY
Please check one:

Chapter 448, Wisconsin Statutes
570 (11/85)

- ☐ By Written FLEX Examination and Oral State Board - $405.00 Fee Attached.
- ☐ By Endorsement of National Board certificate. Scores must be sent directly to this office from National Boards - $40.00 Fee Attached.
- ☒ By Endorsement of FLEX (3 days at one sitting-75% weighted average) or 75% on Component I and 75% on Component II. Direct certification from Federated Boards is required - $40.00 Fee Attached.
- ☐ By Endorsement of State Board exam taken prior to 1972. Scores must be certified by the State Board and sent directly to this office. $50.00 Fee Attached.
- ☐ By Endorsement of LMCC taken after 1/1/78. Direct certification from the Medical Council of Canada is required. $40.00 Fee Attached.

TEMPORARY LICENSE ISSUED PRIOR TO PERMANENT
(Endorsement Candidates only)
- ☐ $10.00 Fee Attached.

Information requested is required for processing this application.

APPLICATIONS MUST BE ACCOMPANIED BY:

Notarized copy of professional diploma & translation if necessary.

Certificate of Professional Education (completed by medical school).

Notarized certificate of completion of one year of post-graduate training in the U.S., or Canada.

Signed & notarized Authorization & Waiver forms.

Unmounted notarized photograph of applicant.

Fee(s)

Notarized copy of ECFMG cert. if F.G.

Letters from all State Boards where licensed. (Includes Active and Inactive Licenses)

I hereby make application for a license to practice medicine and surgery in the State of Wisconsin and submit the following statement concerning my age, professional education and practice, and professional character.

NAME: Shelley Sella

DATE & PLACE OF BIRTH August 8, 1957 Tel-Aviv, Israel

ADDRESS: (number, street, city, state, zip)
1714 Helena St. Madison, WI 53704

PRE-PROFESSIONAL EDUCATION: (schools, locations, dates of graduation, & degrees) (list all schools attended)

	SCHOOL	DEGREE	DATES OF GRADUATION
1.	University of Wisconsin, Madison	B.A	
2.			
3.			

PROFESSIONAL EDUCATION: (schools, locations, dates of graduation, & degrees) (list all schools attended)

1. Sackler School of Medicine, Israel May 1986 M.D.
2.
3.
4.

POST-GRADUATE TRAINING AND PRACTICE: (Outline in chronological order all post-graduate training and practice from the date of graduation from medical school to the present time)

	NAME OF HOSPITAL OR CLINIC	LOCATION	DATES (from-to)
1.	St. Mary's Hospital	Madison, WI	June 1986-present
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED
X Yes ___ No	X Yes ___ No		

SPECIALTY BOARD CERTIFICATIONS **DATE CERTIFIED**

1. _____

What specialty do you practice at the present time? _____

I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED)

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS, THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

1. Are you familiar with the State Health Laws and Rules & Regulations of the Wisconsin Division of Health regarding communicable diseases? yes
2. Have you ever been denied a license by, or the privilege of taking an examination before any State Medical Examining Board? no If "yes", explain and give name of Board _____
3. Have you ever been notified by a state medical licensing board of charges against you? no
   If "yes", where? _____ Give details. _____
4. Have any of your licenses or certificates to practice medicine and surgery ever been restricted, revoked, suspended, limited, surrendered or cancelled, or has any other disciplinary action been taken against your licenses or certificates? no
   If "yes", give details. _____

5. Have any payments been made by yourself, or on your behalf, in settlement of any claims arising out of your practice of medicine and surgery without the commencement of formal legal action? no If "yes", submit name and address of claimant.

Date of payment. _____ Name of insurance company _____

6. Have you ever been a defendant or a respondent in a medical malpractice action or proceeding? no If "yes", when? _____ Identify court or forum in which the action or proceeding was brought _____ What was the disposition of the action or proceeding? _____ Are any such actions or proceedings now pending? _____ Attach copies of all formal pleadings, including, but not limited to the following: complaint, answer, submission of controversy, petitions, etc. Also attach copies of all documents relevant to the ultimate resolution of the matter, including, but not limited to the following: Findings of Fact, Conclusions of Law and Orders; Judgments; Stipulations or Agreements of Settlement? Consent Decrees, etc.

7. Has Drug Enforcement Administration ever withdrawn your DEA number or warned you? no If "yes", give details.

8. Do you have any felony or misdemeanor charges pending against you? no If "yes", give details _____ Identify court _____

9. Have you ever entered a plea of guilty or no contest to a misdemeanor or felony or had a jury verdict of guilty, court finding of guilty or judgment of conviction against you for a misdemeanor or felony? no Give details _____

10. Have you ever received inpatient or outpatient care for mental illness or drug or alcohol abuse? no If "yes", give details,

11. Have your hospital staff privileges ever been limited or removed? no If "yes", give details. _____

12. Have you ever failed to pass any State Medical Board examination, National Board examination, or Flex examination? no If "yes", give details _____

REQUEST FOR TEMPORARY LICENSURE (For Endorsement Candidates Only)

If you are requesting temporary licensure in order to begin practicing prior to the next oral examination, complete this section.
I hereby make application for a Temporary License to practice medicine and surgery at _____,
Street Address, City,
Wisconsin, beginning _____ 19_____ I clearly understand that this license, if issued, will expire 30 days after the next oral examination which is scheduled for _____ 19_____ I understand that if I do not appear at the next oral examination schedule after the effective date of my temporary license, the temporary license will not be valid beyond the first day of the scheduled oral examinations. **TEMPORARY LICENSES MUST BE APPROVED BY TWO MEMBERS OF THE BOARD AND APPROVAL CANNOT BE REQUESTED UNLESS COMPLETED APPLICATION AND ALL SUPPORTING DOCUMENTS ARE ON FILE.**

All applicants must complete this affidavit

I, the above named applicant on being duly sworn, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my license.

2-25-97 Shelley Sella
Date Applicant's Signature

Subscribed and sworn to before me this 25th day of February, 19 87

Pamela J. Luedtke, Notary Public in and for the State of Wisconsin

My commission expires February 18, 19 90

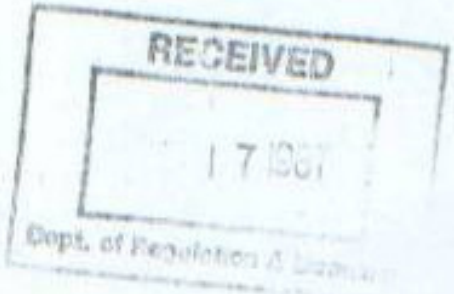
NOTARY SEAL

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 08-13-87
TIME: 9:36 PM



NAME: SELLA,SHELLEY, M.D.
ADDRESS: 1714 HELENA ST
MADISON WI 53704
BIRTHPLACE: TEL-AVIV/ISR
BIRTHDATE: 08/08/57
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
UNIV OF TEL AVIV, SACKLER SCH OF MED,TEL AVIV
YEAR OF GRADUATION: 1986
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: NOT CLASSIFIED
SELF DESIGNATED SPECIALTIES
PRIMARY: UNSPECIFIED
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: NONE REPORTED TO DATE
PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE
FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED

09

The Federation of State Medical Boards

of the United States

INCORPORATED

BRYANT L. GALUSHA M.D.
EXECUTIVE VICE PRESIDENT

2630 WEST FREEWAY SUITE #136
FORT WORTH, TEXAS 76102-7199
(817) 335-1141

DALE G. BREADEN
ASSOCIATE EXECUTIVE VICE PRESIDENT

To: Wisconsin Department of Registration and Licensing.

Subject: FLEX Scores

SHELLEY SELLA
1714 HELENA ST
MADISON, WI
53704

It is certified that the named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 570808015 Date of Certification: 02/27/87

DATE OF EXAM	STATE TAKEN FOR	STATE ID #	COMP 1	COMP 2
06/86	NEW YORK	00257	78	82

COMPONENT 1 of NEW FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy. It assesses basic and clinical science competencies in a clinical context, placing special emphasis on the basis of morbidity, mortality, need for immediate recognition, and the extent to which physician intervention is critical in diagnosis and treatment.

COMPONENT 2 of NEW FLEX is designed to assess the further cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients. It assesses additional cognitive competencies in the context of diseases and problems frequently encountered by the independent practitioner. About 1/3 of Component 2 is devoted to clincial encounters in the hospital setting (in-patient). The remainder of Component 2 includes clinical encounters in non-hospital settings (physician's office, clinic, out-patient facility, emergency room).

DISCIPLINARY SEARCH:

* * * * * * * * * * * * * * * * *

A search of the Federation's Disciplinary Data Bank reveals no reported disciplinary information on the above named physician.