



MEDICAL BOARD OF CALIFORNIA LICENSE LOOKUP SYSTEM

License Information:

The following information is maintained by the Medical Board of California. For more information, click on the blue tabs above.

License:	G 76977 Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the NBME examination.
License Type:	Physician and Surgeon
Name:	LAURA LUCILLE NORRELL, M.D.
Address of Record:	1580 VALENCIA ST STE 508 SAN FRANCISCO, CA 94110
Address of Record County:	SAN FRANCISCO
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:	June 28, 1993
Expiration Date:	May 31, 2013
School Name:	UNIVERSITY OF ALABAMA SCHOOL OF MEDICINE
Year Graduated:	1991

Survey Information:

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

Activities In Medicine:	PATIENT CARE - 30 TO 39 HOURS RESEARCH - NO HOURS TEACHING - 1 TO 9 HOURS ADMINISTRATION - 1 TO 9 HOURS
Primary Practice Location Zip Code:	94110
Board Certification(s):	No board certifications identified
Primary Practice Area(s):	OBSTETRICS & GYNECOLOGY
Secondary Practice Area(s):	No secondary practice areas identified
Post Graduate Training Years:	4 YEARS
Ethnic Background:	Declined to Disclose
Foreign Language(s):	SPANISH
Gender:	Declined to Disclose

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, Court Order, Administrative Citation Issued, or License Issued with Public Letter of Reprimand categories below, documents may be available for review. To find out what information is and is not available, please click [here](#).

Administrative Disciplinary Actions:

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 Administrative Disciplinary Actions found.

Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. 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 the public documents.

No Court Orders found.

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 Administrative Actions Taken by Other State or Federal Government found.

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 Felony Convictions found.

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. To see if a conviction has been expunged or dismissed, please contact the court below.

No Misdemeanor Convictions found.**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 Administrative Citations found.**License Issued with Public Letter of Reprimand:**

The Medical Board of California has concurrently issued the applicant a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

No License Issued with Public Letter of Reprimand found.**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 Hospital Disciplinary Actions found.**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 Malpractice Judgments found.**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 Arbitration Awards found.**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 Malpractice Settlements found.

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.

Public Record Documents:

All imaged documents provided by the Medical Board are being made available to provide immediate access for the convenience of interested persons. While the Medical 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 Medical Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. The Medical Board shall not be responsible for any errors or omissions, or for the use or results obtained from the use of this information. The types of documents which are available include, but are not limited to, accusations, decisions, suspension/restriction orders, public letters of reprimand and citations.

No documents found.

Please note that documents with an effective date prior to calendar year 2000 may not be available via the Web. To obtain a copy of the documents not posted on this site, please contact the Central File Room at (916) 263-2525 or click [here](#) for information on ordering public documents.

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](#).



MEDICAL BOARD OF CALIFORNIA
 1426 HOWE AVENUE, SUITE 34, SACRAMENTO, CA 95825-3236
 (916) 920-6411

RECEIVED
 SACRAMENTO
 MEDICAL BOARD
 CALIFORNIA



**APPLICATION FOR PHYSICIAN AND SURGEON'S
 EXAMINATION OR LICENSURE**

93 APR 21 AM 8:47

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

1. Name: Last: Norrell First: Laura Middle: Lucille ✓

2. Other names you have used (include maiden name): _____

3. Social Security Number: _____
See disclosure statement on LIC

4. Address: Number and Street/Rural Route (include apartment number, if any): _____
 City: _____ State: _____ ZIP Code: _____ Country: _____

5. Telephone Number: Home: _____ Work: _____

6. Date of Birth: Mo/Day/Yr: _____ **Place of Birth:** _____

7. Sex: Female Male

8. Are you a U.S. citizen? Yes No
If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? Yes No
If YES, give date previous application was submitted: _____

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

Name	Address	Period of Attendance	
		From (Mo/Yr)	To (Mo/Yr)
<u>DeKalb College</u>	<u>555 N. Indian Cr. Dr. Clarkston GA 30021</u>	<u>8/82</u>	<u>6/83</u>
<u>University of Georgia</u>	<u>Athens GA 30602-6113</u>	<u>9/83</u>	<u>5/87</u>

10.a Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>University of Georgia</u>
Physics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>"</u>
Biology or Zoology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>"</u>

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official sealed transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
<u>University of Alabama School of Medicine</u>	<u>1670 University Blvd. Birmingham AL 35294</u>	<u>Birmingham, AL</u>	<u>07/87</u>	<u>06/91</u>

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance	School Code
<u>University of Alabama School of Medicine</u>	<u>1670 University Blvd. Birmingham AL 35294-0019</u>	<u>6/2/91</u>	L1A

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification?

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure. Yes No

Name	Location	Date	Result
National Boards Pt I	Birmingham AL	6/89	[REDACTED]
Pt II	Birmingham AL	9/90	[REDACTED]
Pt III	San Francisco CA	3/4/92	[REDACTED]

MBC USE ONLY

WRITTEN EXAMINATION

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?

(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs) Yes No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
University of California San Francisco	505 Parnassus Avenue San Fran. CA 94143	OB/GYN residency	6/91	Currently

POSTGRADUATE TRAINING

QUESTIONS 14A-23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes No

15. Have you been licensed to practice medicine in any state or country? Yes No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed. Please include temporary, limited, or provisional licenses.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)

LICENSE DATA

16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

If yes, give details below. Yes No

State	Date	Charge	Disposition

LGS (CF)

L1B

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MRC USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body? You must also list any pending actions or accusations. Yes No

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances? Yes No

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of \$75.00 or less.) Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

Violation and Location	Date	Penalty or Disposition
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you."

GENERAL DATA

L1C



I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about _____ 19__

my age then being _____ years,

color of hair _____,

color of eyes _____,

height _____ ft. _____ in.,

weight _____ lbs.,

identifying marks _____

3 1/2" x 5" Black and White

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

NOTARIZATION PORTION

STATE OF California
COUNTY OF San Francisco

Laura Lucille Norrell being duly sworn, says she is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that she has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

she requests that the Division of Licensing, Medical Board of California, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, she authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Laura Lucille Norrell
Signature of applicant (Write FULL name, not initials)

Signed and sworn to before me this 12th day of April, 1993

Signature of Notary Public Gerard Almendares

Address 3425 25th St. San Francisco, CA. 94110

NOTARY SEAL



My commission expires 6-19-95

L1D



MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411



CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that Laura Lucille Norvell
FULL NAME OF APPLICANT:
of [REDACTED] enrolled in Univ. of Alabama School of Medicine
ADDRESS WHEN ENROLLED NAME OF MEDICAL SCHOOL
Birmingham Alabama on the 30th day of July 19 87
LOCATION MONTH YEAR

and was granted the following credits on enrollment:
Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).
University of Georgia EDUCATIONAL INSTITUTION 9/83-5/87 DATES

Advanced Credits. Credits previously obtained at an approved medical school.*

MEDICAL SCHOOL TOTAL CREDITS DATES

The undersigned further certifies that the records of this institution show that she attended in this institution 2 years of resident instruction of 24 weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

OR she was granted the degree Bachelor/Doctor of Medicine by
 she withdrew from
the above-mentioned medical school on the 2nd day of June 19 91
MONTH

- Anatomy
- Otolaryngology
- Obstetrics and Gynecology
- Radiology, including Radiation Safety
- Tropical Medicine
- Physiology
- Biochemistry
- Pathology, Bacteriology and Immunology
- Ophthalmology

- Dermatology
- Embryology
- Histology
- Human Sexuality as defined in Section 2090
- Medicine
- Surgery, including Orthopedic Surgery
- Urology
- Psychiatry
- Neurology

- Preventive medicine, including Nutrition
- Physical Medicine
- Therapeutics
- Neuroanatomy
- Child Abuse Detection and Treatment
- Geriatric Medicine
- Pediatrics
- Pharmacology
- Anesthesia



Signed and the college seal affixed this 24th day of March, 19 93
BY Harold J. Fallon
Harold J. Fallon, M.D., Dean PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

L2



MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236



CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

PART 1: To be completed by applicant/trainee.		
Last Name Of Trainee: <u>Norrell</u>	First Name: <u>Laura</u>	Middle Initial: <u>L</u>
Current Address: [REDACTED]	Phone Number: [REDACTED]	
City: [REDACTED]	State: [REDACTED]	Zip Code: [REDACTED]
PART 2: To be completed by facility.		
Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".		
Name of Facility: <u>University of California, San Francisco</u> <i>OK</i>		
Address of Facility: <u>505 Parnassus Avenue, BX-0132, San Francisco, CA 94143</u>		
Name of Program Director: <u>James D. Goldberg, M.D.</u>	Phone Number: <u>(415) 476-5192</u>	
Signature of Program Director: <i>James D. Goldberg</i>	Date Signed: <u>4/14/93</u>	
List Categorical Specialty Area of Training: <u>OB/GYN</u>	Date Training Commenced: <u>6/21/91</u>	Date Training Completed: <u>6/20/92</u>
If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each: <u>Straight training in OB/GYN - 12 months</u>		
<p>Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one-year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.</p>		

(OVER)

L3A

PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal.

Name of Director of Medical Education: James J. O'Donnell, M.D. Phone Number: (415) 476-4561

Facility Name: University of California, San Francisco Date Form Completed: 4/19/93

Facility Address: 505 Parnassus Avenue, BX 0132

City: San Francisco State: CA Zip Code: 94143

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

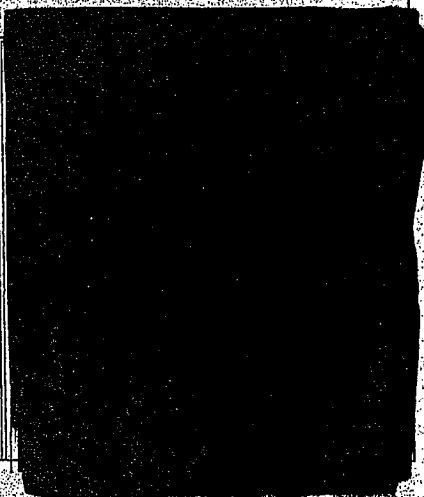
Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Signature of Director of Medical Education: James O'Donnell, M.D.

Date Signed: 4-19-93

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.



L3B



MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVE., STE. 64
SACRAMENTO, CA 95825-3238
(916) 920-6411



CERTIFICATION STATEMENT

This is to certify that Lucretia L. Norrell is in an approved ACGME/CCME postgraduate
 (Name of Physician)
 training position that commenced on June 21, 19 91 and is expected to be completed
 on June 30, 19 95 in Obstetrics and Gynecology
 (Type of Training)
 at University of California, San Francisco DK
 (Name and Address of Facility)
505 Parnassus Avenue, Box 0132, San Francisco, CA 94143

(AFFIX OFFICIAL HOSPITAL
SEAL OR NOTARY PUBLIC SEAL)

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.

James J. O'Donnell, M.D.
Type or print name of Director of Medical Education

James O'Donnell M.D. /es
Signature of Director of Medical Education

April 19, 1993 (415) 476-4561
Date Phone Number

NOTE: Do not use this form in lieu of Form L3 "Certificate of Completion of ACGME Postgraduate Training"

L9

Since you last renewed your license, have you had any license discipline by a government agency or other disciplinary body, or, have you been convicted of any crime in any state in the U.S.A. and its territories, or in a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING.

YES, I WISH TO CONTRIBUTE \$25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

License Renewal Application Physician and Surgeon

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: _____

DATE: 4-11-09

LICENSE NO. G 76977

EXPIRES 05/31/09

ACTIVE LAURA LUCILLE NORRELL
1580 VALENCIA ST STE 508
SAN FRANCISCO CA 94110

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 06/30/09
\$ 830.00	\$ 910.50
TOTAL ENCLOSED = \$ 830.00	
VOLUNTARY FEE = \$ 0.00	

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER () _____

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required here _____

63010700000700006000769778010531090008300000091050

OVER

BANK OF AMERICA 148 CH ST TREAS-DEPT OF CONSUMERS

Health-Related Facility Name Address

G. Financial Interest Statement
 Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

STATE OF CALIFORNIA
 DEPARTMENT OF CONSUMER AFFAIRS
 PO BOX 942520
 SACRAMENTO CA 94258-0520