

BOARD USE ONLY
 License Number: 1301072091
 Date of Licensure: 5-13-98

Board of Medicine
 P.O. Box 30192
 Lansing, Michigan 48909
 (517) 335-0918
 TDD (517) 373-7489

JSW
 11/2/98

APPLICATION FOR LICENSURE

Authority: Public Act 369 of 1978, as amended
 If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 369 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

I AM APPLYING FOR THE FOLLOWING:

I am applying for:
 * License by Endorsement
 * Controlled Substance License
 Fee: 140

- License by Examination Fee: \$140.00
- License by Endorsement (Must Currently be Licensed in Another State) Fee: \$140.00
- Controlled Substance License Fee: \$95.00

Daytime Phone Number 415-643-3927		Previous License Number -
(Last Name) HARRIS	(First Name) LISA	(Middle Name) HOPE
All Previous Names and/or Birth Name Used (if applicable) -		
Date of Birth [REDACTED]	Issue Date (Board Use Only)	
Street Address 4426 25th STREET	Zip Code 94114	
City SAN FRANCISCO	State CA	Social Security Number [REDACTED]

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony? YES NO
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? YES NO
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? YES NO
4. Have you been treated for substance abuse in the past 2 years? YES NO
5. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? YES NO
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? YES NO
7. Have you had one or more settlements, awards, or judgments totaling \$20,000 or more in any consecutive 5 year period? YES NO
8. Have you ever been denied the privilege of taking an examination by any state medical board? YES NO
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? YES NO
10. Do you hold or have you ever held a medical license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.) YES NO

State	License Number	Date of Issue	Basis for Licensure
CALIFORNIA	RO60087	5/2/96	EXAM
HAWAII	MO-9860	5/5/97	ENDORSEMENT

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance		Degree
	From	To	
HARVARD COLLEGE	9/85	6/89	A.B.
HARVARD MEDICAL SCHOOL	9/89	6/94	MD

Provide a description of your professional medical experience. Attach additional sheets if necessary.

Name and address of Employer	Dates of Practice		Duties
	From	To	
University of California, San Francisco (UCSF)	6/21/94	6/30/95	Intern
U.C.S.F.	7/1/95	present (completion anticipated 6/25/98)	Resident

CERTIFICATION

I understand that it is the policy of this agency to secure conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant

Frank D. Davis

Date

3/9/98



NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

CONSUMER & INDUSTRY SV
DEPT. OF CIS-OMS
APR 29 98

Recipient: Michigan Bd of Medicine
PO Box 30192
Lansing, MI 48909

Date: 04/27/1998

Examinee: Lisa Hope Harris

Examinee ID: 3-425-087-8

Date of Birth: [REDACTED]

NBME Certification Date: 02/01/1996

Certificate#: 425087

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Score Scale</u>	<u>Total Score</u>	<u>(Min. Pass)</u>
06/1991	[REDACTED]	Three-Digit Two-Digit	[REDACTED]	[REDACTED]

USMLE STEP 2

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Three-Digit Scale</u>		<u>Two-Digit Scale</u>		<u>Comments</u>
		<u>Total Score</u>	<u>(Min. Pass)</u>	<u>Total Score</u>	<u>(Min. Pass)</u>	
09/1993	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

USMLE STEP 3

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Three-Digit Scale</u>		<u>Two-Digit Scale</u>		<u>Comments</u>
		<u>Total Score</u>	<u>(Min. Pass)</u>	<u>Total Score</u>	<u>(Min. Pass)</u>	
12/1995	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

*** END OF DOCUMENT ***

See reverse side for explanation of information reported above.

Michigan Department of Consumer and Industry Services
Board of Medicine
 P.O. Box 30192
 Lansing, Michigan 48909
 (517) 335-0918
 TDD (517) 373-7489

CONSUMER & INDUSTRY SVCS
 DEPT. OF CIS-CMS

MAR 16 98

CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

SECTION I - APPLICANT INFORMATION

Applicant's Name (Last, First, Middle) HARRIS, LISA HOPE	
Street Address 4426 25 th STREET	
City SAN FRANCISCO	
State CA	ZIP Code 94114
Social Security Number [REDACTED]	Date of Birth [REDACTED]

Signature of Applicant Lisa Harris	Date 3/9/98
---------------------------------------	----------------

Applicant: Upon completion of Section I, send this form to the director of your medical education for completion of Section II on the reverse side of this form.

THIS SIDE TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on the reverse side of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital University of California, San Francisco Medical Center	
Street Address of Hospital 505 Parnassus Ave., Box 0132	
City, State and ZIP Code San Francisco, CA 94143	
I certify that <u>LISA HOPE HARRIS</u> a graduate of the (Applicant's Name)	
<u>Harvard</u> medical school, has successfully completed postgraduate	
clinical training offered by the hospital named above from <u>June 21</u> , 19 <u>94</u> , to <u>June 20</u> ,	
19 <u>98</u> , in the clinical area of <u>Obstetrics, Gynecology and Reproductive Sciences</u>	
Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<u>James O'Donnell M.D.</u> Signature of Director of Medical Education	<u>3-13-98</u> Date of Signature
<u>James J. O'Donnell, M.D.</u> Print or Type Name of Director of Medical Education	
SEAL	
If hospital has no seal, please indicate.	
NOTE: Certification of 2 years postgraduate training will not be accepted if signed and submitted more than 15 days prior to actual completion.	

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION

CONSUMER & INDUSTRY SERVICES
DEPT. OF CIS-015
30010 RICHARDS STREET
P.O. BOX 3469
HONOLULU, HAWAII 96801

MAR 23 98

03/13/98

MICHIGAN DEPT OF CONSUMER AND
INDUSTRY SERVICES
OFFICE HEALTH SERVICES
PO BOX 30670
LANSING MI 48909

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 03/13/98 FOR
LISA H HARRIS

BOARD/COMMISSION: BOARD OF MEDICAL EXAMINERS
LICENSE TYPE: PHYSICIAN
LICENSE IDENTIFICATION: MD 9860
METHOD OF LICENSURE: NATIONAL BOARD EXAM OR NATIONAL CERTIFICATION.
DATE LICENSED: 05/05/97
LICENSE STATUS: DELINQUENT
LICENSE EXPIRATION DATE: 01/31/98
DISCIPLINARY ACTION: NONE

ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

- NO DEROGATORY INFORMATION IS ON FILE.
- THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

Constance Cabral-Makanani

CONSTANCE CABRAL-MAKANANI
EXECUTIVE OFFICER



MEDICAL BOARD OF CALIFORNIA

Licensing Program
1426 Howe Avenue #58
Sacramento, CA 95825
(916) 263-2360

DEPT. OF INDUSTRY SVCS
DEPT. OF CIS-OMS

APR -6 98



March 26, 1998

Michigan Board of Medicine
P.O. Box 30018
Lansing, MI 48909

TO WHOM IT MAY CONCERN:

This is to verify that Dr. Lisa Hope Harris was issued California and physician and surgeon's certificate #A60087, on 5/2/96, based on a written examination. The license is current and renewal fees are paid through 10/31/99.

There is no current record of accusation and/or disciplinary activity.

A handwritten signature in cursive script that reads 'Nancy Jurisich'.

Nancy Jurisich
Licensing Program

To expedite the verification process, the above is standard format used by the Medical Board of California.

SEAL