

# State Medical Board of of Offio ${ }^{\text {opase }}$ 

30 E. Broad St., $3^{\text {rd }}$ Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: FEBmed ${ }_{3}$ ohiogov/ RECEIVED

## Ohio Addendum to Application Ohio Training Program

Are you or will you be in an accredited training program in Ohio?
$\boxed{\otimes}$ Yes
$\square$ No If yes, identify name of training program and location:


## Specialty Boards

| Name of Specialty Board <br> (If none, enter "N/A") | Year Certified | Country |
| :--- | :--- | :--- |
|  |  |  |
|  |  |  |
|  |  |  |

TOEFLIBT
(International Medical School Graduates only)
THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL IBT

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

|  | YES | NO |
| :--- | :---: | :---: |
| Have you completed two years of undergraduate college work in the United States? | $\square$ |  |
| During the five years immediately preceding the date of your application, have you: <br> (Please note you must be able to answer "YES" to both parts of this question) <br> Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the <br> United States? <br> $\quad$ AND | $\square$ |  |
| Have you been actively practicing medicine (graduate medical education is included) in the <br> United States? | $\square$ |  |
| Have you completed a Fifth Pathway program? | $\square$ | $\square$ |
| Have you passed the Clinical Skills Assessment examination given by ECFMG on or after <br> July 1, 1998? | $\square$ | $\square$ |

If you answered NO to all of the above questions, you must take the TOEFL IBT. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

Ohio Addendum to Application

TO BE COMPLETED BY ALL APPLICANTS




FOR BOARD USE ONLY
CERTIFICATE OF PRELIMINARY EDUCATION

$$
\text { no: } 115640
$$

DATE ISSUED: FEB 112009

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the Statutes of Ohio and the regulations of the State Medical Board of Ohio
$\qquad$ $1 / 28 \mid 09$

## Ohio Addendum to Application Additional Information Medicine or Osteopathic Medicine

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

## (Please place a $\square$ in the yes or no box)

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

## Ohio Addendum to Application <br> Additional Information - Medicine or Osteopathic Medicine <br> RECEIVEIO

10. Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?
11. Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?
12. Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
13. Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
14. Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?
15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.

16 Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.
17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
19. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?
20. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?
Applicant Name: Perriera, Lisa Kim
Ohio License Application Form
TA User: iperri03 Date:_1|28/09$\frac{\text { Addendum Page } 5}{}$

## Ohio Addendum to Application Additional Information - Medicine or Osteopathic Medicine


#### Abstract

YES NO 21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? 22. a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?


If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

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For purposes of questions 23 and 24 the following phrases or words have the following meaning
"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
4. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25 , O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.
a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.
b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
Applicant Name: Perriera, Lisa Kim
Ohio License Application Form

Ohio Addendum to Application

## Additional Information - Medicinf OR Opteopathic Medicine

"Chemical substances" is to be construed to include alcohol, drugs, or medications including thoser taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.
24. Do you use chemical substance(s) which in any way impair or limit your ability to
practice medicine with reasonable skill and safety?
a) Are the limitations or impairment caused by your use of chemical substances
reduced or ameliorated because you receive ongoing treatment (with or without
medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.
b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

For purposes of question 25 the following phrases or words have the following meaning:
"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.
25. Are you currently engaged in the illegal use of controlled substances?
a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.


## State Medical Board of Ohio



## Ohio Addendum to Application Certificate of Recommendation Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE $\mathbb{N}$ WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. The recommending physician must sign this form in front of a notary. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM BLACK \& WHITE PHOTOS ARE NOT AGCEPTABLE

1. $\frac{\text { Mitchell Creluin }}{\text { (recommending physician, print name legibly) }}$ , a licensed and practicing physician in the state of $\qquad$ affirm that $\qquad$ has been known to me personally for $\qquad$ 2 years (applicant, print name legibly)
and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excelent
- His/her command of the English language is: perfect
- Additional comments: $\qquad$
I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.



# State Medical Board of Ohio 

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> Ohio Addendum to Application Certificate of Recommendation Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. The recommending physician must sign this form in front of a notary. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

## DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM BLACK \& WHITE PHOTOS ARE NOT ACCEPTABLE


, a licensed and practicing physician in the state of $\qquad$
has been known to me personally for $\qquad$ 2 years
and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Superior
- His/her relationship with patients is: Superior
- I rate his/her ability to work well with peers and medical staff as: $\qquad$
- His/her command of the English language is: Superior
- Additional comments: She is an excellent doctor.

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.



Date Commission Expires


## NOTARY SEAL

TAUser

## 076724

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) 'passport quality, color photograph of yourself to this form. Take the form to a notary publicgnd gignthe form in the presence of the notary public. The notarized form then must be sent directly to this Board. STATE MEDICAL BOARS

## Affidavit

And
Authorization For Release of Information

FEB 032009
RECEIVED I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application,
that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my applicadion and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial y revocation, or other disciplinary sanction of my licensure or permit to practice medicine.


Applicant's Signature (must be signed in the presence of a notary)
Perrier
Applicant's Printed Last Name
Lisa Kim
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)
if 29.09
Date of signature

Dated
State of
 SUBSCRIBED AND SWORN TO before me this MONH $2 Q_{4} t_{4}$ IVAN IA My commission expires: $\quad 3 / d i(0)\left\{\begin{array}{c}\text { Notarial Soul } \\ \text { Dale A. Daley, Noway Public (NOTARY PUBLIC S(GNATURE \& SEAL) } \\ \text { City Of Pittsburgh, Allegheny County }\end{array}\right.$ My Commission Expires Nisi. 21, 2009

Date:

# Bureau of Professional and Occupational Affairs <br> P. O. Box 2649 <br> Harrisburg, PA $17105-2649$ www. dos. state. pa. us <br> <br> OHIO STATE MEDICAL BOARD 

 <br> <br> OHIO STATE MEDICAL BOARD}

February 6, 2009

FED 107009 Recenter

## CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

| NAME: | LISA KIM PERRIERA |
| :--- | :--- |
| LICENSE TYPE: | Medical Physician and Surgeon |
| LICENSE NUMBER: | MD 430904 |
| ORIGINAL LICENSURE DATE: | $02 / 15 / 2007$ |
| EXPIRATION DATE: | $12 / 31 / 2010$ |
| STATUS: | Active |

The license is in good standing and the records indicate no derogatory information.


SEAL
Commissioner
Bureau of Professional and Occupational Affairs

## Licensure Verification Form

(Copy this form for multiple licenses)
I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:


## TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee:

|  | Last | First | Middle |
| :--- | :--- | :--- | :--- |

License Type $\qquad$ License \#: $\qquad$ Issue Date: $\qquad$ Expiration Date:

Is this license current? $\square$ Yes $\square$ No If No, please explain:

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?Yes $\square$ NoCannot answer under state law If Yes, please explain:
2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
$\square$ Yes $\square \mathrm{N}$
$\square$ NoCannot answer under state law If Yes, please explain: $\qquad$ OHIO STATE MEDICAL BOARJ

Board Authorized Signature: $\qquad$
FEB 102009
Title: $\qquad$ RECEIVED

[^0]Date: $\qquad$

United States

Medical
Licensing Examination 7m

## This document was prepared by the

Federation of State Medical Boards of the United States, Inc
Federation Place, PO Box. 619850, Dallas, TX 75261-9850 - Telephone (817) 868-4041

Date : 02/27/2009

## Recipiënt:

Federation Credentials Verification Service ATTN: FCVS

Packet ID:
100500
Examinee: $\quad$ Perriera, Lisa Kim
Alt Name(s):

| Examinee ID\#: | $5-084-148-5$ |
| :---: | :---: |
| Date of Birth: | $06 / 04 / 1975$ |

Alt Name(s):

Resulis for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing scorc ("MP") on each scale is shown in parentheses.


NOTE: A search of the Board Action Data:Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

## OHIO STATE MEDICAL BOARD

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## INTERPRETATION OF RESULTS

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., Incomplete. On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 260 . The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the threedigit scale and 1 to 3 points on the two-digit scale.

## STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.
Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USAMLE examinations in the USMLE Bulletin of Information and from periodic CS updates, available at the USMLE website (svww.usmle.org).

## ANNOTATIONS APPEARING UNDER "COMMENES"

Circumstances in connection with an administration shownon $\longrightarrow$ this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. No score is reported. Information regarding the nature of the indeterminate score and the determination of the Committee
on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

## ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the dociment.

## BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included imthe Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

## Date Posted: 1/6/2010 6:51:52 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

## Address Information

CREDENTIAL MAIL ADDRESS

MAIN $\begin{array}{r}2171 \text { Briarwood Rd. } \\ \text { Cleveland Heights, } 44118 \\ \text { Cuyahoga County } \\ \text { United States of America } \\ \text { lperri03@hotmail.com }\end{array}$

## License Information



## Specialty Codes

1. Please select one specialty from the field below

OBSTETRICS \& GYNECOLOGY
2. Please select one specialty from the field below, if applicable.

$$
\text { . . . . . . \{not Answered }\}
$$

3. Please select one specialty from the field below, if applicable.

$$
\text { . . . . . . \{not Answered }\}
$$

## CME-Physicians

1. Have you met the above CME requirements for your license?

## Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? ........ NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
. . . . . . . NO
6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

## Social Security Number

1. 

## Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

NO
2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
\{not Answered\}

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/29/2012 9:43:24 PM
Please review all information you have provided. Click on the "Review" button to
change any information given or click on the "I Agree" button to verify that all
information posted below is correct and to proceed to payment options.
Please note that knowingly providing false information may result in denial of
registration.

## License Information

License Number 35.093242
License Name Lisa Perriera

## Fees

Relicensure Fee $\$ 305.00$

Total Fees $\mathbf{\$ 3 0 5 . 0 0}$

## Medical Board Correspondence Email

## 1. Did you provide a Credential email address? Please note this information is a public record.

YES

## Specialty Codes

1. Please select one specialty from the field below

OBSTETRICS \& GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
....... \{not Answered\}
3. Please select one specialty from the field below, if applicable.
\{not Answered\}

## CME-Physicians

1. Have you met the above CME requirements for your license?

YES

## Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
. . . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
3. Have any malpractice awards been paid by you or on your behalf for acts
occurring in any state other than Ohio?
.........NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?

NO
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

## Social Security Number

1. 

## Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

NO
2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

$$
\text { . . . . . . \{not Answered }\}
$$

## Ohio Employment

1. Do you practice in Ohio?

YES

## Ohio Workforce Questions

1. "Clinical" - direct patient care
2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose
3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)
4. "Education" - preceptor, mentor, etc.15-19
5. "Volunteering" - providing medical and medical-related services at no cost ..... 1-4
6. "Other" - medical professional activities not included in above categories ..... 5-9
Clinical - Practice setting
7. Enter the number of hours per week spent in "Office/Clinic/Ambulatorycare" (out-patient care).20-24
8. Enter the number of hours per week spent in "Hospital (in-patient care)". ..... 1-4
9. Enter the number of hours per week spent in "Emergency Room".1-4
10. Enter the number of hours per week spent in "Urgent Care".5. Enter the number of hours per week spent in "Other".1-4
Workforce Counties
11. Enter the first zip code:
44106
12. Enter the first county:
Cuyahoga
13. Enter the second zip code: ..... 44143
14. Enter the second county: .....  . \{not Answered\}
15. Enter the third zip code:
....... \{not Answered\}
16. Enter the third county:
. . . . . . \{not Answered\}
Practice Arrangement (size)
17. Solo practitionerNO
18. Single-specialty Group ..... $10+$
19. Multi-specialty Group

## N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)
YES

## Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

NO

## ABMS Certified

1. Are you certified by an ABMS Board?

NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

## Address Information

CREDENTIAL MAIL ADDRESS 2171 Briarwood Rd Cleveland Heights, 44118
Cuyahoga County
United States of America
646-732-5472
lisa.perriera@uhhospitals.org
MAIN
2171 Briarwood Rd. Cleveland Heights, 44118
Cuyahoga County
United States of America
lisa.perriera@uhhospitals.org

## License Information

## License Number

35.093242

License Name
Lisa Perriera

## Fees

Relicensure Fee \$305.00

Total Fees $\mathbf{\$ 3 0 5 . 0 0}$

## Medical Board Correspondence Email

## 1. Did you provide a Credential email address? Please note this information is a public record.

YES

## Specialty Codes

1. Please select one specialty from the field below . . . . . . . OBSTETRICS \& GYNECOLOGY
2. Please select one specialty from the field below, if applicable.

$$
\text { . . . . . . . \{not Answered }\}
$$

3. Please select one specialty from the field below, if applicable.

$$
\text { . . . . . . }\{\text { not Answered }\}
$$

CME-Physicians

1. Have you met the above CME requirements for your license?

YES

## Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

$$
\mathrm{NO}
$$

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
4. Has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
. . . . . . . NO
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

## Social Security Number

1. 

## Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
$\qquad$
2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

## Ohio Employment

1. Do you practice in Ohio?

YES

## Ohio Workforce Questions

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authorizations with insurers, claims, billing issues, etc.)
4. "Education" - preceptor, mentor, etc.
5. "Volunteering" - providing medical and medical-related services at no cost $\quad$...... . 0
6. "Other" - medical professional activities not included in above categories $\quad \ldots . .$. . $1-4$

Clinical-Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).
2. Enter the number of hours per week spent in "Hospital (in-patient care)".
3. Enter the number of hours per week spent in "Emergency Room".
4. Enter the number of hours per week spent in "Urgent Care".
.0
5. Enter the number of hours per week spent in "Other".

## Workforce Counties

1. Enter the first zip code:
2. Enter the first county:
3. Enter the second zip code:
4. Enter the second county:
5. Enter the third zip code:
6. Enter the third county:
\{not Answered\}
7. Do you have more than one practice location?

YES

## Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip.

Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

11100 Euclid Avenue, Cleveland OH, 44106

## Practice Arrangement (size)

1. Solo practitioner
2. Single-specialty Group
3. Multi-specialty Group

N/A
4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

YES

## Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

## ABMS Certified

1. Are you certified by an ABMS Board?

## ABMS Specialty

1. Choose specialty from the dropdown list.

Obstetrics and Gynecology
2. Choose specialty from the dropdown list.
\{not Answered $\}$
3. Choose specialty from the dropdown list.
\{not Answered\}

## NPI number

1. Please enter your current NPI number

DEA number

1. Please enter your DEA number

FP0244513

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.


[^0]:    Please return this form to the Board listed at the top of this form.

