STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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PETE WILSON, Governor

93 JUN 18 AM 9:02

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CA 95825-3236
(916) 920-6411

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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.**

MBC USE ONLY

PERSONAL DATA

015016 6/18/93 6/21/93

1. Name: Last HANSON First MARILEE Middle ANN

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)
477 Crestmont Drive

City SAN FRANCISCO, State CALIFORNIA ZIP Code 94131 Country U.S.A.

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.

NON-MEDICAL EDUCATION

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)	Period of Attendance To (Mo/Yr)
University of California Irvine	Irvine, California	10/80	6/86

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

Course	Yes	No	Name of College or University
Chemistry	✓		University of California, Irvine (UCI)
Physics	✓		Macalester College, St Paul, MN
Biology or Zoology	✓		UCI

MEDICAL EDUCATION

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)	Period of Attendance To (Mo/Yr)	CME	TRANS
STANFORD UNIV	PALO ALTO, CA	STANFORD UNIV.	9/86	6/91	☐	☐
					☐	☐
					☐	☐
					☐	☐

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
STANFORD University	Palo Alto, CA	6/16/91	CA011

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

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L1A

MBC USE ONLY

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

WRITTEN EXAMINATION

NB

☑
☐
☐
☐

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		OB/Gyn	6/91	present

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

LCS CE

☐ ☐
☑ ☐
☐ ☐
☐ ☐

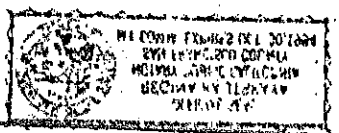
16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

If yes, give details below. Yes No

State	Date	Charge	Disposition

☑
☐
☐

L1B



MBC 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

"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

TOP

BOTTOM

3½" x 5" Black and White

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 _____

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)

MARILEE ANN HANSON
PRINT FULL NAME OF APPLICANT

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.

Marilee Ann Hanson, MD
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 17 day of June, 1993.

Regina Kautskaya
Signature of Notary Public

OFFICIAL SEAL
REGINA KAUTSKAYA
NOTARY PUBLIC CALIFORNIA
SAN FRANCISCO COUNTY
MY COMM. EXPIRES OCT. 30,1994

Oct. 30, 1994

Address 525 Arguello Blvd. S.F.

My commission expires Oct. 30, 1993

07A-100 (REV. 7/91)

L1D

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

RECEIVED
SACRAMENTO
MEDICAL BOARD

PETE WILSON, Governor

State of California Department of Consumer Affairs

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

93 JUN -3 AM 9:08

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OF LICENSING

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that MARILEE ANN HANSON
FULL NAME OF APPLICANT

of 2333 EASTRIDGE AVE. MENLO PARK, CA 94225 enrolled in STANFORD UNIVERSITY SCHOOL OF MEDICINE
ADDRESS WHEN ENROLLED NAME OF MEDICAL SCHOOL

PALO ALTO, CALIFORNIA on the 1ST day of OCTOBER 1986
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 California, Irvine — 10/80 – 6/86
EDUCATIONAL INSTITUTION DATES

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

~~The MD degree from Stanford, although this has had~~ no less than 4000 hours of instruction covering ~~the topics listed on the application.~~
MEDICAL SCHOOL DATES

The undersigned further certifies that the records of this institution show that he attended in this institution ~~_____ years of~~ RECEIVED SUFFICIENT HOURS OF MEDICAL INSTRUCTION AND UNIT OF CREDIT ~~resident instruction of _____ 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

NUMBER YEARS
NUMBER OF WEEKS

XX he was granted the degree Bachelor/Doctor of Medicine by

OR ☐ he withdrew from

the above-mentioned medical school on the 16TH day of JUNE 1991
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 25TH day of MAY, 1993.

BY Geneva Lopez for Jack Farrell
PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph

STANFORD UNIVERSITY
STANFORD, CA . 94305

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

MAY 25 1993

* 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.

JACK R. FARRELL
ACTING REGISTRAR

07A-100-12 (REV. 11/91)

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

Consumer Affairs

PETE WILSON, *Governor*

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: HANSON | First Name: MARILEE | Middle Initial: A

Current Address: 497 Crestmont Drive | Phone Number: , ,

City: SAN FRANCISCO | State: CA | Zip Code: 94131

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: University of California, San Francisco

Address of Facility: 505 Parnassus Avenue, BX 0132, San Francisco, CA 94143

Name of Program Director: James D. Goldberg, M.D. | Phone Number: (415) 476-5192

Signature of Program Director: [signature] | Date Signed: 4/9/93

List Categorical Specialty Area of Training Completed by Trainee: OB/GYN | Date Training Commenced: 6/21/91 | Date Training Completed: 6/20/92

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Straight training in OB/GYN - 12 months

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 gynacology, 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.

(OVER)

07A-100-L3 (Rev. 2/92)

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:	4/8/93
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 J. O'Donnell M.D./ks
Date Signed:	4-13-93

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

L3B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

State of California Department of Consumer Affairs

PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, STE. 54
SACRAMENTO, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that MARILEE ANN HANSON (Name of Physician) is in an approved ACGME/CCME postgraduate 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 (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 MD JS
Signature of Director of Medical Education

April 8, 1993
Date

(415) 476-4561
Phone Number

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

07A-100-L9 (Rev. 12/92)

L9

PART 3

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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: M A Hanson DATE: 10/26/08

F. ☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

H. ☐ YES, I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 11/30/08
76967	10/31/08	$805.00	$885.50
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE MARILEE ANN HANSON
710 EAST 24TH ST STE 403
MINNEAPOLIS MN 55404

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.

M A Hanson
Signature required here

6301070000070000600076967901103108000805000008855O

002947 80 63010700006 000769679 102908
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

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

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.

31 805 00

Health-Related Facility Name	Address
Mildred S Hanson, MD PA	710 E 24th St #403 Mpls MN 55404

SMBCLS 02/28/05

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.

Health-Related Facility Name	Address
Marilee Hanson MDPA	710 East 24th Street, Suite 403
	Minneapolis, MN 55404

004617 71 63010700006 000769679 082410
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

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

SMBCLS 03/28/09

PART I

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body; or, have you been convicted of any crime in any state, the U S A and its territories, military court or a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

License Renewal Application
Physician and Surgeon

F. ☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

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: _____

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 11/30/10
76967	10/31/10	$786.00	$864.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE MARILEE ANN HANSON
710 EAST 24TH ST STE 403
MINNEAPOLIS MN 55404

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

OVER

63010700000700006000769679011031100007860000086400

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/26/2012 **To Date:** 07/26/2012

ATRISUPPINF

21-OCT-14 10:30:30

Person Id : 978764 **Name :** Hanson,Marilee

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	MILDRED S. HANSON, M. D. PA, 710 E. 24TH ST, STE 403, MPLS, MN 55404
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	NO

Total Questions Asked For Person : 978764 8