STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE Aug 23 1 48 PM

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.**

002730 307.50 … 0981

005966 255.00 12/86

BMQA USE ONLY

1. Name: Last Sella First Shelley Middle

PERSONAL DATA

2. Other names you have used:

3. Social Security Number — See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number)
519 Chestnut St.

City	State	ZIP Code	Country
Santa Cruz	CA	95060	U.S.A

5. Telephone Number: Home — Work N/A

6. Date of Birth: Mo/Day/Yr

7. Sex: [X] Female [ ] Male

8. Are you a U.S. citizen? [X] Yes [ ] No — 4 59442
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California? [ ] Yes [X] No
If YES, give date of previous application:

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Wisconsin	Madison, Wisconsin	9/1976	12/1981

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

MEDICAL EDUCATION — CME — TRANS.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Sackler School of Medicine	Ramat Aviv, Israel	SAME	9/1982	5/1986

15R 02
School Code

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Sackler School of Medicine	Ramat Aviv, Israel	May 20, 1986

[redacted]

07A-100 — **L1A**

L1V

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WRITTEN EXAMINATION

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
FMGEMS	[illegible]	[illegible] 23, 1985	
	[illegible]	[illegible] 24, 1985	
FLEX	NEW YORK, NY	JUNE 1986	

POSTGRADUATE TRAINING

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☒ 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)	Period of Attendance To (Mo/Yr)
ST. MARYS HOSPITAL	707 S. MILLS ST MADISON, WI	FAMILY PRACTICE RESIDENCY	7/1986	7/1987

LICENSE DATA

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.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	Dates of Practice in Issuing Agency's Jurisdiction To (Mo/Yr)	LGS	CE
NEW YORK	171295	7/30/1987	7/1987	12/1988	☒	☐
WISCONSIN	28642	7/1/1987	7/1987	11/1989	☒	☐
					☐	☐
					☐	☐

16. Has any disciplinary action ever been 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.

Yes ☐ No ☐ If yes, give details below:

State	Date	Charge	Disposition

002ECE

L1B

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LICENSE DATA (continued)

GENERAL DATA

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? ☐ Yes ☐ No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? ☐ Yes ☐ No If yes, please explain on a separate sheet of paper.

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 If yes, please explain on a separate sheet of paper.

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 If yes, please explain on a separate sheet of paper.

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, or to drug addiction? ☐ Yes ☐ No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

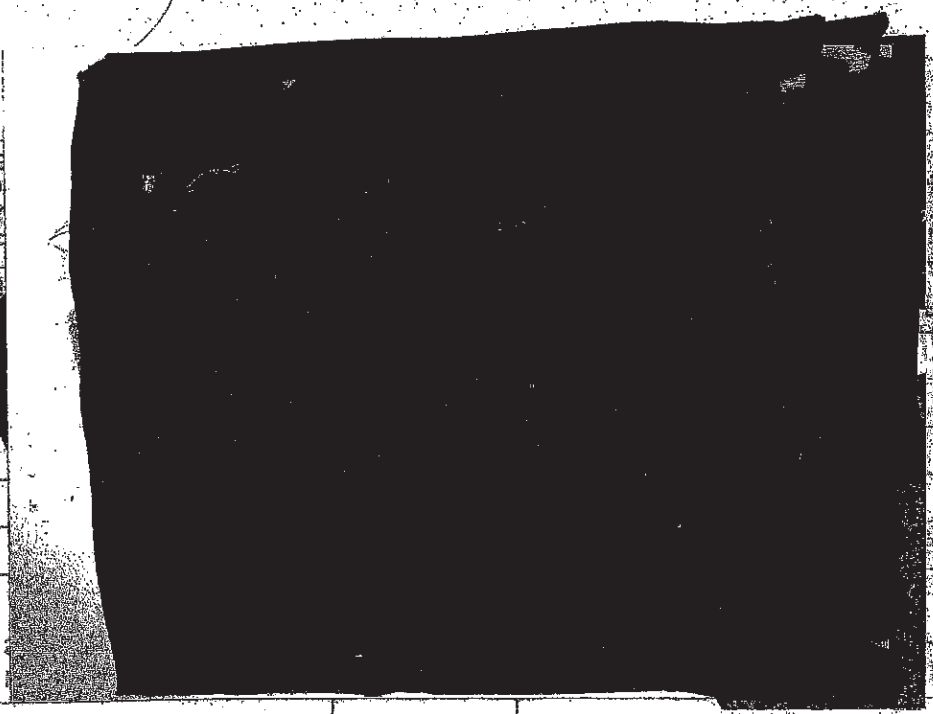
23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) ☐ Yes ☐ No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"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."

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 88

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.

STATE OF ____

COUNTY OF Santa Cruz

Shelley Sella being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he 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.

He requests the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he 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.

Shelley Sella

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 16th day of August 19 88

Signature of Notary Public Teri Shaw

TERI SHAW
NOTARY PUBLIC - CALIFORNIA
SANTA CRUZ COUNTY
My commission expires Mar. 31, 1992

[SEAL]

Address 1840 41st Ave, Capitola, Ca. 95010

My commission expires 3-31-92

07A-100

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME 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 below. Please type or print.

This is to certify that Shelley Sella (NAME OF APPLICANT),

a graduate of Sackler School of Medicine (NAME OF MEDICAL SCHOOL),

formally commenced an accredited postgraduate training program at St. Mary's Hospital, 707 S. Mills St. Madison, WI (NAME AND ADDRESS OF FACILITY) in Family Practice (SPECIALTY),

on July 1, 1986, and completed such training on June 30, 1987.

This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
1. Internal Medicine	4 months
2. Ob/Gyn	3 months
3. ER	1 month
4. Pediatrics	2 months
5. Surgery	2 months

[redacted]

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 was trained in an approved ACGME or CCME program position.

NAME Marie Hanson MD (DIRECTOR OF MEDICAL EDUCATION)
MARIE F. HANSON

ADDRESS 707 S. MILL STREET
MADISON, WI 53715

PHONE NUMBER 608 263 1701

DATE 16 AUG 1988

SIGNATURE Marie Hanson

L3

07-A100 Connie Thompson 8/15/88

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Shelley Sella (FULL NAME OF APPLICANT)

of 131 E. 64th St. NY, NY 10021 (ADDRESS WHEN ENROLLED) enrolled in Sackler School of Medicine (NAME OF MEDICAL SCHOOL)

Tel Aviv Univ., Tel Aviv Israel (LOCATION) on the 5 day of September (MONTH) 1982 (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 Wisconsin, Madison (EDUCATIONAL INSTITUTION) 1976-1981 (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 he attended in this institution 33 (SPECIFY NUMBER) courses of resident instruction of 32/32/34/39 (NUMBER OF WEEKS) 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

☒ he was granted the degree ~~Bachelor~~/Doctor of Medicine by

☐ he withdrew from

the above mentioned medical school on the 20 day of May (MONTH) 1986.

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

[redacted]

Signed and the college seal affixed this 19 day of July, 1988

BY Susan Goldberg
Susan Goldberg, Registrar (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.

07A-100

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AG

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

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QUALITY ASSURANCE

OCT 14 11 39 AM '88

CERTIFICATE OF CLINICAL TRAINING

Must have two certificates for each clerkship, one by instructor and one by facility program director.

This is to certify that Shelley Sella (STUDENT'S NAME), a student of Sackler School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Mount Sinai Hospital (NAME AND ADDRESS OF FACILITY) 4 wks

One Gustave L. Levy Place, New York, N.Y. 10029

from July 29 (DATE) 19 85 thru August 23 (DATE) 19 85 in the clinical area of Internal Medicine (CLINICAL AREA). That the above named student successfully completed this clerkship on August 23 (DATE) 19 85

I, Samuel K. Elster, M.D. being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☒ is ☐ is not affiliated with a U.S. medical school.

Name of U.S. medical school if affiliated: Mount Sinai School of Medicine

Samuel K. Elster, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

One Gustave L. Levy Place,
ADDRESS

New York, N.Y. 10029

PHONE NUMBER (212) 427-7700

Samuel K. Elster
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

CYNTHIA GRUBER
Notary Public, State of New York
No. 31-4638796
Qualified in New York County
Commission Expires February 28, 1989

Signed and sworn to before me this 6th day of October, 1988

Cynthia Gruber
NOTARY PUBLIC

457 W. 57
ADDRESS

NOTARY SEAL

My commission expires

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES A[illegible]CY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

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SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

OCT 14 11 39 AM '88

CERTIFICATE OF CLINICAL TRAINING

Must have two certificates for each clerkship, one by instructor and one by facility program director.

This is to certify that Shelley Sella (STUDENT'S NAME), a student of Sackler School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Mount Sinai Hospital (NAME AND ADDRESS OF FACILITY) One Gustave L. Levy Place, New York, N.Y. 10029 from July 29 (DATE) 19 85 thru August 23 (DATE) 19 85 in the clinical area of Internal Medicine (CLINICAL AREA). That the above named student successfully completed this clerkship on August 23 (DATE) 19 85.

Richard M. Stein, M.D. being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☒ is ☐ is not affiliated with a U.S. medical school.

Name of U.S. medical school if affiliated: Mount Sinai School of Medicine

Richard M. Stein, M.D., Vice Chairman, Dept. of Medicine
TYPE OR PRINT. NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

One Gustave L. Levy Place,
ADDRESS

New York, N.Y. 10029

PHONE NUMBER (212) 241-8848

Richard M. Stein
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

Signed and sworn to before me this 6th day of October, 19 88

Cynthia Gruber
NOTARY PUBLIC

NOTARY SEAL

457 W. 57
ADDRESS

CYNTHIA GRUBER
Notary Public, State of New York
No. 31-4639796
Qualified in New York County
Commission Expires February 28, 19 89

My commission expires 2/28/89

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

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(916) 920-6411

SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE

OCT 28 1 26 PM '88

CERTIFICATE OF CLINICAL TRAINING

Must have two certificates for each clerkship, one by instructor and one by facility program director.

This is to certify that Shelley Sella (STUDENT'S NAME), a student of Sackler School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by University of Wisconsin, Department of Family Practice (NAME AND ADDRESS OF FACILITY) 777 S. Mills St., Madison, WI 4 Hawks from October 1 (DATE) 19 85 thru October 31 (DATE) 19 85 in the clinical area of Family Practice (CLINICAL AREA). That the above named student successfully completed this clerkship on October 31 (DATE) 19 85.

Catherine Soderquist, MD being duly sworn, says she is/was the individual instructor and program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☑ is ☐ is not affiliated with a U.S. medical school.

Name of U.S. medical school if affiliated: University of Wisconsin

Catherine Soderquist, MD
TYPE OR PRINT NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

777 S. Mills St,
ADDRESS

Madison, WI 53715

PHONE NUMBER (608) 263-4550

Catherine Soderquist
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

Signed and sworn to before me this 27th day of October, 1988

Sara J. Marx
NOTARY PUBLIC

1501 Fusch Road, Madison WI 53711
ADDRESS

My commission expires 5-13-90

NOTARY SEAL

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

07A-100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES A[illegible]Y — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Must have two certificates for each clerkship, one by instructor and one by facility program director.

This is to certify that Shelley Sella (STUDENT'S NAME), a student of Sackler School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by University of Wisconsin Department of Family Practice (NAME AND ADDRESS OF FACILITY)
777 S. Mills St., Madison, WI 4 Weeks

from Sept. 1, (DATE) 1985 thru Sept. 30 (DATE) 1985 in the clinical area of Family Practice (CLINICAL AREA). That the above named student successfully completed this clerkship on Sept. 30 (DATE) 1985.

Catherine Soderquist, MD being duly sworn, says she is/was the individual instructor ~~or~~ and program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☒ is ☐ is not affiliated with a U.S. medical school.

Name of U.S. medical school if affiliated: University of Wisconsin

Catherine Soderquist MD
TYPE OR PRINT NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

777 S. Mills St.,
ADDRESS

Madison, WI 53715

PHONE NUMBER (608) 263-4550

Catherine Soderquist
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

Signed and sworn to before me this 27th day of OCTOBER, 1988

Sara J. Marx
NOTARY PUBLIC

1501 Frisch Road, Madison WI 53711
ADDRESS

NOTARY SEAL

My commission expires 5-13-90

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

07A-100

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/03/2012 **To Date:** 07/03/2012

ATRISUPPINF

09-JAN-15 15:29:48

Person Id : 535638 **Name :** Sella,Shelley

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.	NONE
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 : 535638 8