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SCAN SHEET
GENERATED 07/17/2008

NAME: KANESHIRO BLISS E K

LICENSE ID: MD13799

FULL LIC ID: MD 0013799000

___ MICROFICHE PRESENT

___ OTHER UNSCANNED ITEMS PRESENT-DESCRIPTION

- ___ BOUND MATERIAL
- ___ PHOTO
- ___ OTHER

_____

_____

FILE PREP BY: _____ DATE: _____

CONTROL#: [redacted]

4/25/06

Application for License - PHYSICIAN (MD License) or PHYSICIAN employed by Hawaii State or County Government (MDG License)

Read instructions and requirements on attached sheet before completing this application.

Effective Date: 4/24/06

License No.: MD - 13799

MD - 4013 MDG - 1845

RECEIVED
APR 26 2006

Circle type of license applying for: (MD) MDG

Legal Name (First-Middle): Bliss Emi Kanani

(Last): Kaneshiro

Residence Address (include apt. no., city, state and zip code): [redacted]

Mailing Address (ONLY if different from above):

Social Security No.: [redacted]

Phone No. (days): [redacted]

Other names used: —

Birth date: [redacted]

FOR OFFICE USE ONLY

323	00013691	13- 7/21/05	50.00
312	00013692	13- 7/21/05	75.00
324	00013693	13- 7/21/05	90.00
300	00013694	13- 7/21/05	75.00

Circle answers:

1) Are you at least 18 years of age? [redacted]
2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the U.S.?
3) Are you a graduate of a U.S. or Canadian medical school? YES NO
4) Are you a graduate of a Foreign medical school (FMG)? YES (NO)

Circle answers and provide details as directed for any "yes" response to the questions below:

5) Have you ever held a license in Hawaii? (YES) NO
If response "yes," specify type of license and dates below:
Hawaii licence for residency training from 7/1/01 to 7/8/05

6) With regard to any medical license to practice in any state or country:
   a) Has it ever been revoked, suspended, placed on probation, surrendered, reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement? YES (NO)
   b) Is any disciplinary action pending against you? YES (NO)
   c) Are you presently being investigated? YES (NO)
   d) Have you ever been denied a license or withdrawn an application for licensure? YES (NO)
   If response "yes," attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action.

7) With regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
   a) Have you ever been subject to disciplinary or adverse actions or entered into an agreement? YES (NO)
   b) Is any disciplinary or adverse action pending against you? YES (NO)
   c) Are you presently being investigated? YES (NO)
   d) Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership? YES (NO)
   If response "yes," attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction or organizations involved, relevant dates, action taken and reasons for such action.

8) With regard to professional liability:
   a) Have any claims of malpractice ever been filed against you? YES (NO)
   b) Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage? YES (NO)
   If response "yes," attach a detailed explanation on a separate sheet, which:
   - *includes the date of the case (month/year), jurisdiction (State, etc.) nature of the case, allegations, and amount paid on your behalf. Information is to be provided on all settlements, judgments, awards, and claims (including those for which no money was paid); and/or*
   - *provides the name and address of your insurance carrier, specific circumstances, date and action taken.*

(Continued on Back)

End:	App/Lic	323/312	$50/$75
Gov:	App/Lic	323/312	$25/$50
	CRF	324	$45/$90
	½ Ren	300	$75
	Service Fee	BCF	$ 15

9) With regard to participation in any health plan or Federal or State health care program:
   a) Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation? ..... YES (NO)
   b) Have you ever been convicted of insurance fraud? ..... YES (NO)
   If response "yes," attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction relevant dates, allegations, charges, disposition, action taken and reasons for such action.

10) In the past five years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? ..... [redacted]
   If response "yes," attach a detailed explanation on a separate sheet.

11) During the past twenty years, have you been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES (NO)
   Explain "yes," response on a separate sheet with detailed information and attach supporting documents.

	Name of Jurisdiction	Date Issued	License Number	Date Verification Requested
LICENSES	Hawaii	7/2001	MDR4013	

	Hospital Affiliation (If none, state "None") Name of Hospital	Location (City/State or Country)	Dates (mo/yr) From	To	Date Form Requested
AFFILIATION					

	Name of Medical School	Location (City/State or Country)	Degree Earned	Dates (mo/yr) From	To
EDUCATION	University of Hawaii	Honolulu / HI	MD	8/1997	5/2001

	Name of Residency Program	Location (City/State or Country)	Dates (mo/yr) From	To
RESIDENCY	Hawaii Residency Program	Honolulu / HI	7/2001	7/2005

	Training or Experience Name of Hospital	Location (City/State)	Dates (mo/yr) From	To	Date Verification Requested
TRAINING/ EXPERIENCE					

CERTIFICATION OF APPLICANT:

I certify that all the information contained on this application and the supporting documents submitted are true and correct. I understand that this certification and any misrepresentation are grounds for the denial or subsequent revocation of a license.

Signature of Applicant

6/29/05
Date

RECEIVED PVL
LICENSING BRANCH
2005 JUL -1 A 11:06
DEPT OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

7/1/05

BOARD OF MEDICAL EXAMINERS

APPLICANT CHECK-OUT SHEET – REGULAR & GOVERNMENT LICENSE

Name of Applicant KAMSKARD Date Filed 7/1/05

(ALL SUPPORTING DOCUMENTS MUST BE LESS THAN ONE (1) YEAR OLD WHEN LICENSE IS ISSUED)

[✓] Application (revised 10/03 or later) Date of Birth [redacted]

[✓] Fee: $290 (2/1, even to 1/31, odd) Social Security No. [redacted]
$170 (2/1, odd to 1/31, even)

[✓] AMA/Canadian clearance
(Verify birthdate, MD school, intern residency or fellowship, states where licensed)

[✓] + Exam Scores
NB 1 2 3
FLEX 1 2 (After '85, must pass 75 each part)
USMLE 1 2 3 (Must pass all parts 3 within 7 years)
MCCQE (Qualifying exam of LMCC)

[✓] NPDB (Verify name, birthdate, SS#, states licensed in, any reports (actions))

[✓] * MD diploma transcript or letter from Dean
[✓] U.S. or Canada Graduate
[ ] Foreign Graduate

[✓] Intern/resident certificate or letter from program director
[✓] U.S. or Canada graduate with 1 year residency
[ ] Foreign graduate with 2 years residency

[✓] ^ Hospital Affiliation (All hospitals in last 3 years. Must answer A & C or B & C).
(If none, state "None".)
[✓] 1. UH
[ ] 2.
[ ] 3.
[ ] 4.

[✓] ^ License verifications: (Any state wherever licensed current or not. Check for disciplinary action including states listed on AMA.)
[✓] 1. WDR - 4013 - AP 7/8/05 [✓] 4. WA - on file
[ ] 2. OK per LIC 7/20/05 [ ] 5.
[ ] 3. [ ] 6.

[✓] + Federation Discipline Report
(Need if took NB)
(Not needed if took USMLE/FLEX-it will be with Exam Scores)

[ ] FOREIGN GRAD: (In addition to above requirements)
[ ] + ECFMG Certification or Fifth Pathway certification
[ ] + MCCEE
[ ] + Visa Qualifying Exam

[ ] LIMITED GOVERNMENT LICENSE: (In addition to above requirements)
[ ] Fee: $120
[ ] Employment Confirmation
All other requirements, same as "Regular License" (Exam can be State-produced exam).

* Copies acceptable
\+ Being sent directly to BME
^ Fax acceptable if comes directly w/cover letter

MD-04 1204R

7/1/5

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

USMLE United States Medical Licensing Examination™

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: 06/07/2005

Recipient:
Hawaii Board of Medical Examiners
ATTN: Kathy Smith, Transcripts, Licensing Div
Dept. of Consumer Affairs
P.O. Box 3469
335 Merchant Street 3rd Floor
Honolulu, HI 96813

Examinee: Kaneshiro, Bliss
Examinee ID#: [redacted]
Date of Birth: [redacted]
All Name(s): Kaneshiro, Bliss Emi Kanani

Results 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 score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
[redacted]	Pass	[redacted]	179	[redacted]	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
[redacted]	Pass	[redacted]	174	[redacted]	75	

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
HAWAII [redacted]	Pass	[redacted]	182	[redacted]	75	

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

RECEIVED JUN 8 2005

Patent 5636874

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination results is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word VALID will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT, will appear prominently across the face of the entire document.

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 three-digit scale and 1 to 2 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 USMLE examinations in the *USMLE Bulletin of Information* and from periodic CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on 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 document.

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 in the 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".

The Regents of

The University of Hawai'i

on the recommendation of the Faculty at

University of Hawai'i at Mānoa

have conferred upon

Bliss Emi Kanani Kaneshiro

the degree of

Doctor of Medicine

with all its privileges and obligations

Given at Honolulu, Hawai'i, this thirteenth day of May,
two thousand one

Ted Cadwell
Dean, School of Medicine

Chairperson, Board of Regents

Kenneth P. Mortimer
President and Chancellor

University of Hawaii
John A. Burns School of Medicine
Resident Training Program in Obstetrics, Gynecology and Women's Health

This Certifies that

Bliss Emi Kanani Kaneshiro, M.D.

has satisfactorily completed 48 months service as a

Resident in Obstetrics, Gynecology and Women's Health

IN WITNESS WHEREOF the undersigned have affixed their signatures

this 30th day of June, 2005

Program Director, Department of Obstetrics and Gynecology
John A. Burns School of Medicine
University of Hawaii

Chair, Department of Obstetrics and Gynecology
John A. Burns School of Medicine
University of Hawaii

Dean
John A. Burns School of Medicine
University of Hawaii

UNIVERSITY OF HAWAI'I AT MĀNOA

John A. Burns School of Medicine
Department of Obstetrics, Gynecology and Women's Health

July 1, 2005

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

To Whom It May Concern:

This is to verify that Bliss Kaneshiro, MD is currently a resident with the University of Hawaii Obstetrics and Gynecology Residency Program. Dr. Kaneshiro began the program on June 21, 2001 as an intern and has successfully completed her first, second and third years of residency. As of this date, she is a fourth-year resident and we anticipate that Dr. Kaneshiro will complete her four-year Ob/Gyn residency training on July 8, 2005.

Sincerely,

Tod C. Aeby, MD
Program Director

HOSPITAL AFFILIATION – PHYSICIAN

Access this form via website at: www.hawaii.gov/dcca/pvl

TO THE APPLICANT: Complete the *"Applicant"* section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency during any part of the most recent **3 years** preceding your application for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both sides.

APPLICANT

Name (First-Middle)	(LAST)	Social Security No.	Birthdate
Bliss Emi Kanani	Kaneshiro,	[redacted]	
Date Served/Applied:	**Capacity Served or Applied for**	**Name of Hospital/Residency Program**	
7/2001 to 7/2005	resident	Hawaii Residency Program	

To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR

I am applying for a license to practice medicine and surgery in Hawaii. The board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency. For my residency program, the program director may complete this form. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii State Board of Medical Examiners in connection with my application. Please complete the following questionnaire, SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and **return the material directly to the address on the reverse side.**

Date 6/29/05

Signature of Applicant

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

Please complete A and C or B and C as applicable

A. **POSTGRADUATE TRAINING:**

1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... (YES) NO
2. Briefly evaluate applicant's competence and conduct during the program: [redacted]
3. [redacted] applicant's participation in the program? ..... YES (NO)

If response "yes," please explain and attach copies of material from your records: _____

B. **HOSPITAL PRIVILEGES:**

1. Were privileges extended to the applicant? ..... YES (NO)
2. Please describe privileges: _____
3. Was applicant rejected privileges? ..... YES (NO)

If response "yes," please explain and attach copies of material from your records: _____

4. Were privileges ever limited, revoked, suspended or restricted? ..... YES (NO)

If response "yes," please explain and attach copies of material from your records: _____

C. **SAFE PRACTICE COMMENTS:**

1. Is there anything in your files which could call into question applicant's ability to safely practice medicine? ..... YES (NO)

If response "yes," please explain: _____

2. Derogatory information, if any: _____

(CONTINUED ON BACK)

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Date 7/1/05

Signature of Chief of Staff, Administrator or Program Administrator

Name Tod C. Aeby, MD

Title Program Director

Hospital/Residency Program University of Hawaii Obstetrics and Gynecology Residency Program

Address 1319 Punahou Street, Suite 824

Honolulu, Hawaii 96826

Phone No. (808) 203-6500

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)
none

RECEIVED PVL
LICENSING BRANCH
2005 JUL -5 A 10:19
DEPT OF COMMERCE
& CONSUMER AFFAIRS
STATE OF HAWAII

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

April 20, 2006

State of Hawaii Medical Boards

To Whom It May Concern:

I, Betty Elliott, Licensing Representative, do hereby certify that a search of the records of the Washington State Department of Health Medical Quality Assurance Commission indicates the following:

PHYSICIAN NAME:	**Bliss, Kaneshiro, MD**
LICENSE NUMBER:	**MD00044771**
ISSUE DATE:	**03-23-2005**
EXPIRATION DATE:	**03-22-2008**

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NO PAST/PENDING DISCIPLINARY ACTIONS

The information above is the only certification information provided by the Commission. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission.

If you have any further questions or need additional information, please contact me by telephone at (360) 236-4785, by email at betty.elliott@doh.wa.gov, or in writing at Department of Health, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

Sincerely,

B Elliott

Betty Elliott, Licensing Representative
Medical Quality Assurance Commission

(STATE SEAL)

FEDERATION DISCIPLINE REPORT - PHYSICIAN

Access this form via website at: www.hawaii.gov/dcca/pvl

TO THE APPLICANT: All applicants who passed the NBME are required to provide completion of this report by the Federation of State Medical Boards.

Complete the APPLICANT section and mail this form to:

Federation of State Medical Boards
P.O. Box 619850
Dallas, TX 75261-9850
Phone: (817) 868-4000

APPLICANT

LAST NAME, First, Middle	Social Security No.	Birthdate
Kaneshiro, Bliss, Emi Kanani	[redacted]	
Medical School of Graduation & Branch Location	**Date of Graduation**	
University of Hawaii	May 2001	

I authorize the Federation of State Medical Boards to indicate on this form if there is any previous or pending disciplinary action against my licenses in any state.

Date 6/29/05

Signature of Applicant

FEDERATION

TO THE FEDERATION: Please indicate below if there is any previous or pending disciplinary action against any licenses of the above-named individual.

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

JUL - 6 2005

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

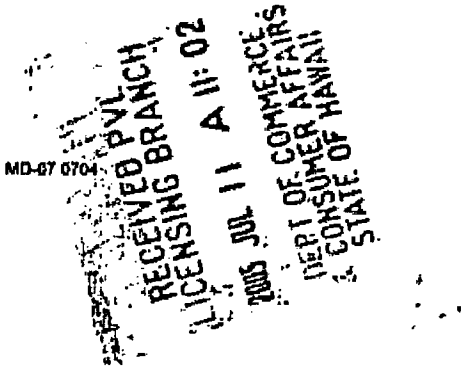
Signature _____

Title _____

Date _____

PLEASE RETURN THIS FORM DIRECTLY TO THE HAWAII BOARD OF MEDICAL EXAMINERS AT THE ADDRESS BELOW:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801



MD-67 0704

I have attached a check for $290. I would like my medical license to be issued for Feb 1, 2006 (even numbered year) rather than Feb 1, 2005. Please call me with any questions: [redacted]

Bliss Kaneshiro MD

BOARD OF MEDICAL EXAMINERS
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

03/28/06 REF: [redacted] MD LICN 000 A3

BLISS E K KANESHIRO
[redacted]

RE: NOTICE OF DEFICIENCY
- PHYSICIAN
- NEW LICENSE

Your application has been received, however, it is incomplete because of the reason(s) noted below. Return this notice (if applicable) with the required items indicated below.

RESPOND BY: 04/07/06

X Verification of license(s) for every jurisdiction in which you hold or ever held a license is required to be sent DIRECTLY to the Board including those for residency training or locum tenens.

X Verification of license has not been received from the following states:
(and any other states listed on the AMA Profile)

WA--LISTED ON YOUR AMA PROFILE

VERIFICATIONS ARE VALID FOR 1 YEAR. SEVERAL OF YOURS ARE DATED 7/1/05. WE URGE YOU TO COMPLETE THE LICENSING PROCESS BEFORE 7/1/06 TO AVOID HAVING TO RE-SUBMIT OUTDATED FORMS.

Return this notice with all items to:

BOARD OF MEDICAL EXAMINERS
DCCA, PVL LICENSING BRANCH
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

Questions? Call (808) 586-3000

BOARD OF MEDICAL EXAMINERS
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

10/21/05 REF: [redacted] MD LICN 000 A3

BLISS E K KANESHIRO
[redacted]

RE: NOTICE OF DEFICIENCY
- PHYSICIAN
- NEW LICENSE

Your application has been received, however, it is incomplete because of the reason(s) noted below. Return this notice (if applicable) with the required items indicated below.

RESPOND BY: 11/04/05

_X_ Verification of license(s) for every jurisdiction in which you hold or ever held a license is required to be sent DIRECTLY to the Board including those for residency training or locum tenens.

_X_ Verification of license has not been received from the following states:
(and any other states listed on the AMA Profile)

WA--LISTED ON YOUR AMA PROFILE

Return this notice with all items to:

BOARD OF MEDICAL EXAMINERS
DCCA, PVL LICENSING BRANCH
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

Questions? Call (808) 586-3000

BOARD OF MEDICAL EXAMINERS
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

08/31/05 REF: [redacted] MD LICN 000 A3

BLISS E K KANESHIRO
[redacted]

RE: NOTICE OF DEFICIENCY
- PHYSICIAN
- NEW LICENSE

Your application has been received, however, it is incomplete because of the reason(s) noted below. Return this notice (if applicable) with the required items indicated below.

RESPOND BY: 09/14/05

X Verification of license(s) for every jurisdiction in which you hold or ever held a license is required to be sent DIRECTLY to the Board including those for residency training or locum tenens.

X Verification of license has not been received from the following states:
(and any other states listed on the AMA Profile)

WA--LISTED ON YOUR AMA PROFILE

Return this notice with all items to:

BOARD OF MEDICAL EXAMINERS
DCCA, PVL LICENSING BRANCH
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

Questions? Call (808) 586-3000

BOARD OF MEDICAL EXAMINERS
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

07/15/05 REF: [redacted] MD LICN 000 A3

BLISS E K KANESHIRO
[redacted]

RE: NOTICE OF DEFICIENCY
- PHYSICIAN
- NEW LICENSE

Your application has been received, however, it is incomplete because of the reason(s) noted below. Return this notice (if applicable) with the required items indicated below.

RESPOND BY: 07/29/05

X All applicants are directed to contact the National Practitioner Data Bank (NPDB) at 1-800-767-6732 or visit their website at www.npdb-hipdb.com to request a form for self-query. We need the ORIGINAL report that says "Search Result - NPDB (not HIPDB), issued not more than 1 year ago.

X Contact the Data Bank for the form. After completing the form, return it directly to the Data Bank. They will send you the report titled "Search Result"-NPDB and then you are to forward the ORIGINAL report to us.

X You must request a physician profile from the American Medical Association (AMA) be sent to us.

X Contact the AMA at (312) 464-5199 to request that physician profile be sent directly to the Board. In the alternative, you may arrange for this on-line at: www.ama-assn.org/. Go to Physicians, then Products and Services and click on Credentialing Products. A profile must be requested regardless of membership.

Return this notice with all items to:

BOARD OF MEDICAL EXAMINERS
DCCA, PVL LICENSING BRANCH
P.O. BOX 3469
HONOLULU, HAWAII 96801-3469

Questions? Call (808) 586-3000

PVL Renewal Application

LICENSE DATA

HAWAII MEDICAL BOARD **PHYSICIAN**

License Number: MD-13799

File Number: [redacted]

LICENSEE INFORMATION

LICENSEE'S NAME AND ADDRESS OF RECORD

BLISS E K KANESHIRO

[redacted]

RESIDENTIAL ADDRESS **CHANGED: NO**

[redacted]

MAILING ADDRESS **CHANGED: NO**

TOTAL (ON TIME) FEE OF: $300.00
BY LICENSE EXPIRATION DATE: 1/31/10

PAYMENT INFORMATION

RENEWAL RECEIVED ON

11/17/09 1:57:41 PM HST

REFERENCE ID

[redacted]

TOTAL AMOUNT PAID

$262.50

PAYMENT METHOD

Credit Card

TOTAL FEES PAID BY

BLISS E K KANESHIRO

BILLING ADDRESS

[redacted]

Survey Answers

1. Do you currently practice medicine in Hawaii?
   Yes
   a. Do you provide patient care at least 20 hours a week in Hawaii? Yes
   b. Are you a resident or fellow in training? N/A
2. Specialty information:
   a. Primary Specialty Obstetrics and Gynecology
   a. Secondary Specialty (if applicable) N/A

3. Office Address (es):
   a. Primary Office Address
   1319 Punahou Street #824
   Honolulu, HI 96826
   b. Secondary Office (if applicable)
   550 S. Beretania Streeet #610
   Honolulu, HI 96813
4. Within the next two years, are you planning to retire, leave or decrease your patient care hours in Hawaii to less than 20 hours a week?
   N/A
5. Within the next two years, do you think your practice region will need more physicians?
   N/A
   If yes, which specialties?

Licensee has answered the following questions

1. In the past two years, with regard to any medical license to practice in any state or country:
   a. Has it ever been revoked, suspended, placed on probation, surrendered reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement?
      No
   b. Is any disciplinary action pending against you?
      No
   c. Have you ever been denied a license or withdrawn an application for licensure?
      No
2. In the past two years, with regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
   a. Have you ever been subject to disciplinary or adverse actions or entered into an agreement?
      No
   b. Is any disciplinary or adverse action pending against you?
      No
   c. Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership?
      No
3. In the past two years, with regard to professional liability, participation in any health plan or federal or state health care program:
   a. Have any claims of malpractice ever been filed against you?
      No
   b. Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage?
      No

c. Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation?
No

d. Have you ever been convicted of insurance fraud?
No

4. In the past two years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects?
[redacted]

5. During the past two years, have you been convicted of a crime in which the conviction has not been annulled or expunged?
No

WAIVER/MODIFICATION OF CME: Any physician not meeting the CME requirement due to incapacity, undue hardship or other extenuating circumstances may request a waiver/modification in writing. The written request must be notarized and include an explanation as to why the CME requirement was not met. **Physicians exercising this option may not renew online**.

If licensed after 01/31/09, no CME's are required.

CERTIFICATION: By submitting this renewal, unless I am requesting a waiver/modification, I certify that I have met the continuing medical education (CME) requirement as contained in Subchapter 5 of the Board's rules.

PHYSICIAN WORKFORCE ASSESSMENT FEE
Pursuant to Act 18 (effective July 1, 2009), Physicians are to be assessed a $60 fee upon the renewal of a medical license. This fee will be transferred to and deposited into the John A. Burns School of Medicine ("JABSOM") special fund to support JABSOM's activities related to physician workforce assessment and planning within Hawaii. For further details, please go to http://hawaii.gov/dcca/areas/pvl/main/press_releases/medical_announcements/.

I understand that my license expires on the License Expiration Date shown above. I understand that if I fail to renew my license by the license expiration date I am unlicensed and shall not practice. I further understand that I may resume practice only after I have met all appropriate restoration requirements.

I certify that the statements contained in this application are true and correct. I understand that misrepresentation is grounds for board refusal to renew or subsequent suspension or revocation of license.

Signature: Bliss Kaneshiro

PVL Renewal Application

LICENSE DATA

HAWAII MEDICAL BOARD **PHYSICIAN**

License Number: MD-13799

File Number: [redacted]

LICENSEE INFORMATION

LICENSEE'S NAME AND ADDRESS OF RECORD

BLISS E K KANESHIRO

[redacted]

RESIDENTIAL ADDRESS **CHANGED: NO**

[redacted]

MAILING ADDRESS **CHANGED: NO**

TOTAL (ON TIME) FEE OF: $300.00
BY LICENSE EXPIRATION DATE: 1/31/12

PAYMENT INFORMATION

RENEWAL RECEIVED ON

11/30/11 12:50:04 PM HST

REFERENCE ID

[redacted]

TOTAL AMOUNT PAID

$300.00

PAYMENT METHOD

Credit Card

TOTAL FEES PAID BY

BLISS E K KANESHIRO

BILLING ADDRESS

[redacted]

Licensee has answered the following questions

1. In the past two years, with regard to any medical or osteopathic medical license to practice in any state or country:

   a. Has it ever been revoked, suspended, placed on probation, surrendered reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement?
   No

b. Is any disciplinary action pending against you?
No
c. Have you ever been denied a license or withdrawn an application for licensure?
No

2. In the past two years, with regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical or osteopathic medical societies and specialty boards:

a. Have you ever been subject to disciplinary or adverse actions or entered into an agreement?
No
b. Is any disciplinary or adverse action pending against you?
No
c. Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership?
No

3. In the past two years, with regard to professional liability, participation in any health plan or federal or state health care program:

a. Have any claims of malpractice ever been filed against you?
No
b. Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage?
No
c. Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation?
No
d. Have you ever been convicted of insurance fraud?
No

4. In the past two years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects?
[redacted]

5. During the past two years, have you been convicted of a crime in which the conviction has not been annulled or expunged?
No

WAIVER/MODIFICATION OF CME: Any physician not meeting the CME requirement due to incapacity, undue hardship or other extenuating circumstances may request a waiver/modification in writing. The written request must be notarized and include an explanation as to why the CME requirement was not met. **Physicians exercising this option may not renew online**.

CERTIFICATION: By submitting this renewal, unless I am requesting a waiver/modification, I certify that I have met the continuing medical education (CME) requirement as contained in Subchapter 5 of the Board's rules.

PHYSICIAN WORKFORCE ASSESSMENT FEE
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I understand that my license expires on the License Expiration Date shown above. I understand that if I fail to renew my license by the license expiration date I am unlicensed and shall not practice. I further understand that I may resume practice only after I have met all appropriate restoration requirements.

I certify that the statements contained in this application are true and correct. I understand that misrepresentation is grounds for board refusal to renew or subsequent suspension or revocation of license.

Signature: Bliss Kaneshiro

Survey Answers

1. **Do you currently practice clinical medicine in HAWAII?**
   Yes
2. **Are you either of the following?**
   N/A
3. **Specialty information:**
   Main Specialty: OBGYN
   Other Specialty (if applicable): N/A
4. **Office Address (es):**
   a. **Primary Office / Location: Address**

      550 S. Beretania Street
      Honolulu, HAWAII 96813
      808-218-7900

   b. **Estimate hours / week at this office**
      20.0
   c. **Are you accepting new patients at this office?**
      Yes
   d. **Are you accepting new Medicare patients at this office?**
      Yes
   e. **Secondary Office / Location: Address**

N/A

f. **Estimate hours / week at this office**
N/A

g. **Are you accepting new patients at this office?**
N/A

h. **Are you accepting new Medicare patients at this office?**
N/A

5. Practice Environment: Medium Group (6-49)
Are you an employee?: Yes

6. Within the next two years, do you think your island will need more practicing physicians?
Yes

If yes, which specialties?
general surgery

PVL Renewal Application

LICENSE DATA

HAWAII MEDICAL BOARD **PHYSICIAN**

License Number: MD-13799

File Number: [redacted]

LICENSEE INFORMATION

LICENSEE'S NAME AND ADDRESS OF RECORD

BLISS E K KANESHIRO

[redacted]

RESIDENTIAL ADDRESS **CHANGED: NO**

[redacted]

MAILING ADDRESS **CHANGED: NO**

TOTAL (ON TIME) FEE OF: $300.00
BY LICENSE EXPIRATION DATE: 1/31/14

PAYMENT INFORMATION

RENEWAL RECEIVED ON

11/6/13 11:51:14 AM HST

REFERENCE ID

[redacted]

TOTAL AMOUNT PAID

$300.00

PAYMENT METHOD

Credit Card

TOTAL FEES PAID BY

BLISS E K KANESHIRO

BILLING ADDRESS

[redacted]

Licensee has answered the following questions

1. Are you a U.S. Citizen, a U.S. National, or an alien authorized to work in the U.S.?

[redacted]

2. In the past two years, with regard to any medical or osteopathic medical license to practice in any state or country:

   a. Has it ever been revoked, suspended, placed on probation, surrendered reprimanded, admonished, or otherwise subject to disciplinary action; or have

you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement?
No

b. Is any disciplinary action pending against you?
No

c. Have you ever been denied a license or withdrawn an application for licensure?
No

3. In the past two years, with regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical or osteopathic medical societies and specialty boards:

   a. Have you ever been subject to disciplinary or adverse actions or entered into an agreement?
   No

   b. Is any disciplinary or adverse action pending against you?
   No

   c. Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership?
   No

4. In the past two years, with regard to professional liability, participation in any health plan or federal or state health care program:

   a. Have any claims of malpractice ever been filed against you?
   No

   b. Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended, or revoked your coverage?
   No

   c. Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation?
   No

   d. Have you ever been convicted of insurance fraud?
   No

5. In the past two years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects?
[redacted]

6. During the past two years, have you been convicted of a crime in which the conviction has not been annulled or expunged?
No

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I certify that the statements contained in this application are true and correct. I understand that misrepresentation is grounds for board refusal to renew or subsequent suspension or revocation of license.

Signature: Bliss Kaneshiro

Survey Answers

1. **Do you provide healthcare to patients in Hawaii?**
   Yes
2. **Do you primarily serve a military or military dependent population?**
   No
3. **Are you still in training (internship, residency or fellowship)?**
   No
4. **What is your primary specialty?** Obstetrics and Gynecology
   Other specialties (if applicable)? N/A
5. **Please tell us about your practice environment(s):**

   What is the primary office address where you see patients?

   a. **Primary Address**

      550 South Beretania Street Suite 610
      Honolulu, HI 96813
      808-218-7900

   b. **Email/web address**
      N/A

c. **How many hours a week do you see patients at this office?**
12.0

d. **Are you accepting new patients at this office?**
Yes

e. **Are you accepting new Medicare patients at this office?**
Yes

f. **Are you accepting new Medicaid or Quest patients at this office?**
Yes

g. **Do you have a secondary office address?**
No

h. **What is the primary office address where you see patients?**

Secondary address

N/A

i. **Email/web address**
N/A

j. **How many hours a week do you see patients at this office?**
N/A

k. **Are you accepting new patients at this office?**
N/A

l. **Are you accepting new Medicare patients at this office?**
N/A

m. **Are you accepting new Medicaid or Quest patients at this office?**
N/A

n. **Do you have any additional office(s) in Hawaii?**
N/A

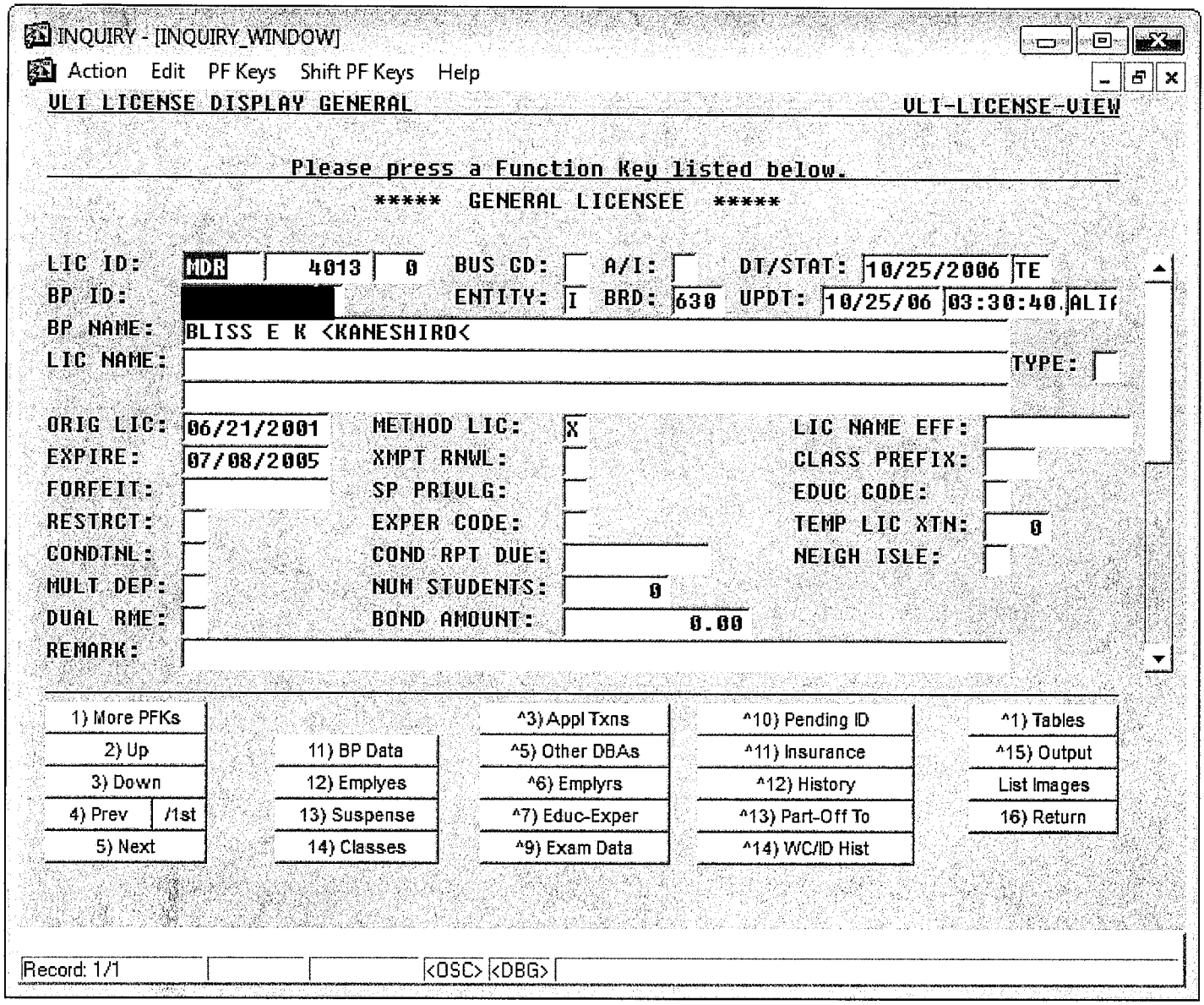
6. **Please check all the terms that apply to your patient care experience in Hawaii**
Employed with no ownership interest, Faculty, Researcher

7. **What is the size of your practice group (how many partners do you have <u>including</u> yourself)?**
11 or more

8. **Do you provide care to Hawaii patients via telemedicine?**
No

9. **Would you like your name and office contact information listed in a directory of Hawaii physicians?**
Yes
(Such a directory does not currently exist, but if there is desire by physicians, we can create a web based Hawaii physician directory. It would only include your name and address contact information, but NO OTHER INFORMATION COLLECTED ABOVE).

10. **Comments and suggestions addressing the survey or the physician workforce needs in Hawaii**
N/A


INQUIRY - [INQUIRY_WINDOW]
Action Edit PF Keys Shift PF Keys Help
VLI LICENSE DISPLAY GENERAL
VLI-LICENSE-VIEW
Please press a Function Key listed below.
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LIC ID: MDR 4013 0
BUS CD:
A/I:
DT/STAT: 10/25/2006 TE
BP ID:
ENTITY: I
BRD: 630
UPDT: 10/25/06 03:30:40 ALI
BP NAME: BLISS E K <KANESHIRO<
LIC NAME:
TYPE:
ORIG LIC: 06/21/2001
METHOD LIC: X
LIC NAME EFF:
EXPIRE: 07/08/2005
XMPT RNWL:
CLASS PREFIX:
FORFEIT:
SP PRIVLG:
EDUC CODE:
RESTRCT:
EXPER CODE:
TEMP LIC XTN: 0
CONDTNL:
COND RPT DUE:
NEIGH ISLE:
MULT DEP:
NUM STUDENTS: 0
DUAL RME:
BOND AMOUNT: 0.00
REMARK:
1) More PFKs
2) Up
3) Down
4) Prev
/1st
5) Next
11) BP Data
12) Emplyes
13) Suspense
14) Classes
^3) Appl Txns
^5) Other DBAs
^6) Emplyrs
^7) Educ-Exper
^9) Exam Data
^10) Pending ID
^11) Insurance
^12) History
^13) Part-Off To
^14) WC/ID Hist
^1) Tables
^15) Output
List Images
16) Return
Record: 1/1
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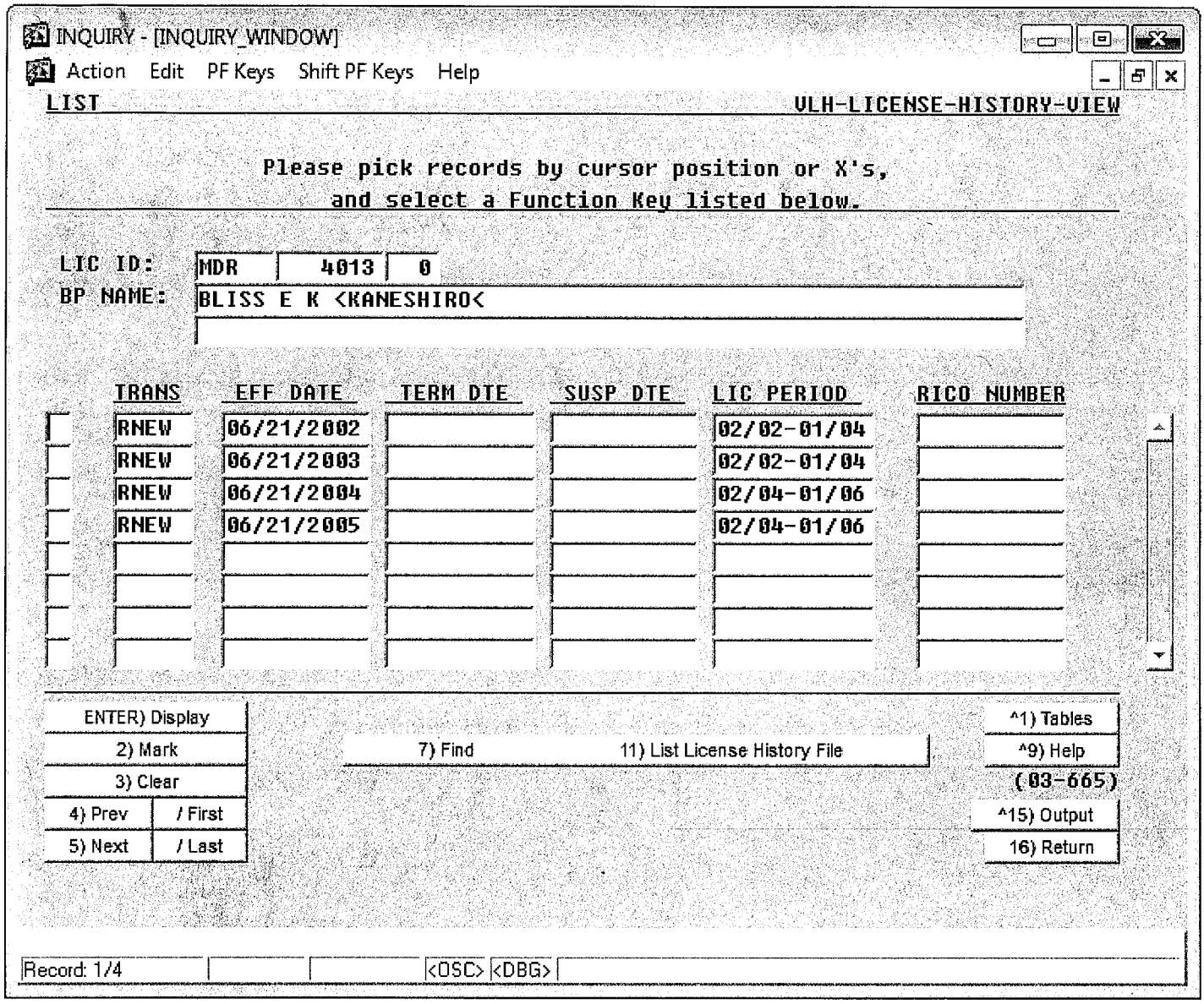
<DBG>


INQUIRY - [INQUIRY_WINDOW]
Action Edit PF Keys Shift PF Keys Help
LIST
VLH-LICENSE-HISTORY-VIEW
Please pick records by cursor position or X's,
and select a Function Key listed below.
LIC ID: MDR 4013 0
BP NAME: BLISS E K <KANESHIRO<
TRANS EFF DATE TERM DTE SUSP DTE LIC PERIOD RICO NUMBER
RNEW 06/21/2002 02/02-01/04
RNEW 06/21/2003 02/02-01/04
RNEW 06/21/2004 02/04-01/06
RNEW 06/21/2005 02/04-01/06
ENTER) Display
2) Mark
3) Clear
4) Prev / First
5) Next / Last
7) Find
11) List License History File
^1) Tables
^9) Help
(03-665)
^15) Output
16) Return
Record: 1/4
<OSC> <DBG>