



**MEDICAL BOARD OF CALIFORNIA**  
 LICENSING PROGRAM  
 2005 Evergreen Street, Suite 1209  
 Sacramento, CA 95815  
 (800) 633-2322 (916) 263-2382 FAX (916) 263-2382  
 www.mbc.ca.gov

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 MEDICAL BOARD OF CALIFORNIA  
 2008 SEP 30 PM 03:31



**INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER**

Application for (please check one):  License  PTAL - or -  Update

1. NAME: Last <b>TODD</b> First <b>MARISA</b> Middle <b>BRIANNE</b>		MBC Use Only	
Other names you have used (include maiden name):		2. U.S. Social Security Number	
3. Place of Birth <b>Bend, Oregon</b>		4. Date of Birth	
5. Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female			
6. Public/Mailing Address: <b>2238 Geary Boulevard, Kaiser Permanente</b> <small>(Please note: this information is public)</small> <small>(30 characters maximum per line, including spaces)</small> <b>San Francisco Medical Center</b>			
City <b>San Francisco</b>	State/Province <b>CA</b>	Zip/Postal Code <b>94115</b>	Country <b>USA</b>
7. Telephone Numbers: (Include area code)		Home	Work Cell
8. California Driver's License Number (optional):		10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Previous license number, if any: _____	
9. E-mail Address (optional):		Parabola Date	

**MEDICAL EDUCATION**

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
<b>Oregon Health Sciences University</b>	<b>Portland, OR USA</b>	<b>8/2003 - 6/2007</b>

12. School of Graduation: **Oregon Health Sciences Univ** Degree Awarded: **Medical Doctor** Date of Graduation: **6/2007**

**EXAMINATIONS**

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or CME in Canada

Examination	Date	Result (Pass/Fail)
<b>USMLE Step 1</b>		
<b>USMLE Step 2</b>		
<b>USMLE Step 3</b>		

0001787 930 895 50 84 00000000 **L1A**

232972



**ABMS CERTIFICATIONS**

MBC  
Use Only  
ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties?  
YES  NO

Member Board	Expiration Date	Certificate Number

**MALPRACTICE HISTORY**

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$30,000 or more?  
YES  NO

**PRACTICE IMPAIRMENT OR LIMITATIONS**

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES  NO
19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES  NO
20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES  NO
21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES  NO
22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES  NO

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

**CRIMINAL RECORD HISTORY**

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application: YES  NO

APPLICANT:

DATE OF BIRTH:

MARISA TODD

**L1C**

**CRIMINAL RECORD HISTORY (cont'd)**

MBC  
Use Only  
Criminal  
Record

- |   |     |    |                          |
|---|-----|----|--------------------------|
| 24. Is any criminal action pending against you?     | YES | NO | <input type="checkbox"/> |
| 25. Are you required to register as a Sex Offender? | YES | NO | <input type="checkbox"/> |

**DISCIPLINARY HISTORY**

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

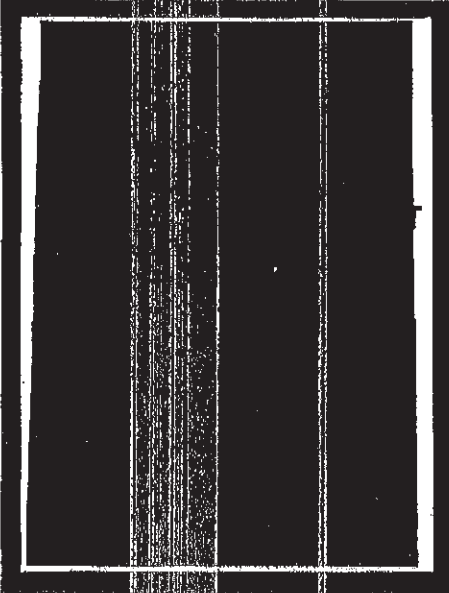
- |   |     |    |                          |
|---|-----|----|--------------------------|
| 26. Have you ever been denied a license to practice medicine?   | YES | NO | <input type="checkbox"/> |
| 27. Is any denial pending against you?  | YES | NO | <input type="checkbox"/> |
| 28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? | YES | NO | <input type="checkbox"/> |
| 29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?  | YES | NO | <input type="checkbox"/> |
| 30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?                         | YES | NO | <input type="checkbox"/> |
| 31. Have you ever had any license to practice medicine subjected to any other disciplinary action?  | YES | NO | <input type="checkbox"/> |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine?   | YES | NO | <input type="checkbox"/> |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?   | YES | NO | <input type="checkbox"/> |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?   | YES | NO | <input type="checkbox"/> |
| 35. Is any disciplinary action pending against your hospital staff privileges?  | YES | NO | <input type="checkbox"/> |
| 36. Have you ever surrendered a license to practice medicine?   | YES | NO | <input type="checkbox"/> |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?  | YES | NO | <input type="checkbox"/> |
| 38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?   | YES | NO | <input type="checkbox"/> |

APPLICANT:

MARISA TODD

DATE OF BIRTH:

**L1D**



Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, MARISA BRIANNE TODD (PLEASE PRINT FULL NAME) \_\_\_\_\_ (DATE OF BIRTH) \_\_\_\_\_ being first duly sworn upon his/her

oath deposes and says; that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

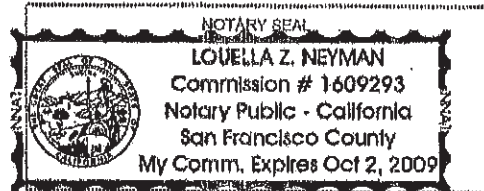
MT (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: *Marisa Brianne Todd* (Please sign full name)

State of CALIFORNIA  
County of SAN FRANCISCO

Subscribed and sworn to (or affirmed) before me on this 2nd day of JUNE, 2008, by MARISA BRIANNE TODD

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.



*Luella Z. Neyman*  
SIGNATURE OF NOTARY PUBLIC

**L1E**



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2008 JUN 20 AM 9:51

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that MARISA B TODD
Full Name of Applicant
enrolled in Oregon Health and Science University
Name of Medical School
located in Portland, Oregon USA on 08/25/2003
State/Province Country Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2) and that the applicant

- Anatomy, Embryology, Physical Medicine, Therapeutics, Neuroanatomy, Child Abuse Detection and Treatment, Geriatric Medicine, Pediatrics, Pharmacology, Anesthesia, Spousal Partner Abuse Detection & Treatment\*, Family Medicine\*\*, Pain Management and End-of-Life-Care\*\*\*
Otolaryngology, Histology, Human Sexuality, Medicine, Surgery, including Orthopedic Surgery, Urology, Psychiatry, Neurology, Alcoholism and Chemical Dependency, Preventative Medicine, including Nutrition
Obstetrics and Gynecology, Radiology, including Radiation Safety, Tropical Medicine, Physiology, Biochemistry, Pathology, Bacteriology, and Immunology, Ophthalmology, Dermatology

\* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
\*\* ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
\*\*\* ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

[X] was granted the degree of Bachelor/Doctor of Medicine on the 8th day of June 2007
[ ] withdrew from medical school on \_\_\_ day of \_\_\_

Unusual Circumstances

Responses

Did this individual ever take a leave of absence from their medical education? Yes No
Was this individual ever placed on probation? Yes No
Was this individual ever disciplined or under investigation? Yes No
Were any incident reports regarding this individual ever filed by instructors? Yes No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? Yes No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below
Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
Signed and the school seal affixed this 17 day of June, 2008.
By: Cherie Honnell / Registrar
Printed Name and Title of School Official
Signature: Cherie Honnell / [Signature]

L2



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 2008 JUL -3 AM 10:09



LICENSING PROGRAM

### CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

#### PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last <b>TODD</b>			First <b>MARISA</b>			Middle <b>B.</b>		
U.S. Social Security Number			Date of Birth			Telephone Number		
						Home Work (		
Public/Mailing Address <b>2425 Geary Blvd.</b>								
City <b>SF</b>			State/Province <b>CA</b>			Zip/Postal Code <b>94115</b>		
Medical School of Graduation: <b>Oregon Health Sciences University</b>								

#### PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

**ATTENTION PROGRAM DIRECTOR:** Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility: <b>KAISER FOUNDATION HOSPITAL</b>			ACGME 10 digit Program number: (www.acgme.org) <b>220 051 2045</b>		
Address of Facility: <b>2425 Geary Blvd. SF CA 94115</b>			Telephone #: <b>415-833-3074</b>		
Categorical Specialty Area of Training <b>ob/gyn</b>		Start Date of Training <b>06/27/2007</b>		End Date (or anticipated completion date) of Training <b>06/30/2011</b>	

#### UNUSUAL CIRCUMSTANCES

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

**L3A**

## DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

**"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.**

## GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1

has completed  has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

  
SIGNATURE OF PROGRAM DIRECTOR

**ATTENTION PROGRAM DIRECTOR:** THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

  
PRINT NAME OF PROGRAM DIRECTOR

  
SIGNATURE OF PROGRAM DIRECTOR  
Signature Stamp is Not Acceptable

  
6/27/08  
DATE SIGNED

If a hospital seal is unavailable, the program director shall sign this form in the presence of a notary public.

State of CALIFORNIA

County of SAN FRANCISCO


Subscribed and sworn to (or affirmed) before me on

this 27th day of JUNE, 20 08

by Robin Field

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

  
LOUELLA Z. NEYMAN  
Commission # 1609293  
Notary Public - California  
San Francisco County  
My Comm. Expires Oct 2, 2009

  
SIGNATURE OF NOTARY PUBLIC

**L3B**





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2008 JUL -3 AM 10:09

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are currently participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

Form fields including NAME (Last: TODD, First: MARISA, Middle: B), U.S. Social Security Number, Date of Birth, Medical School of Graduation (Oregon Health Sciences U.), Training Start/End Dates (06/27/2007 to 06/30/2011), Facility Name (Kaiser Permanente San Francisco), and Facility Address (2425 Geary Blvd, San Francisco, CA 94115).

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR - Signature Stamp is Not Acceptable

DATE

TELEPHONE NUMBER

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

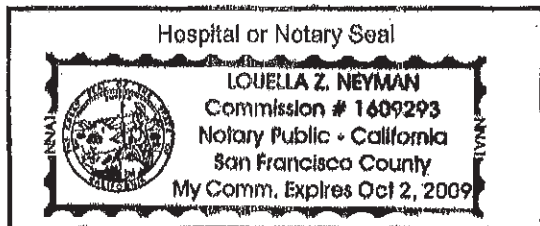
Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of CALIFORNIA
County of SAN FRANCISCO

Subscribed and sworn to (or affirmed) before me on this 27th day of JUNE, 2008 by Robin Field

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.



SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4

**STATE DEPARTMENT OF CONSUMER AFFAIRS  
INTERNET CASHIERING SYSTEM  
MEDICAL BOARD OF CALIFORNIA  
SUPPLEMENTAL INFORMATION REPORT**  
From Date: 07/06/2010 To Date: 07/06/2010

**ATRISUPPINF**

**01-DEC-15 09:37:07**

**Person Id :** 1671544

**Name :** Todd, Marisa

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 <a href="http://www.mbc.ca.gov">www.mbc.ca.gov</a> 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 :** 1671544

**8**