STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

RECEIVED IN CASHIERS
Department of Consumer Affairs
94 NOV 21 PM 12:18

RECEIVED
SACRAMENTO MEDICAL BOARD OF CALIFORNIA
94 NOV 21 AM 10:46

RECEIVED
BOARD OF MEDICAL QUALITY ASSURANCE
94 NOV 22 AM 8:40
DIVISION OF LICENSING

# MEDICAL BOARD OF CALIFORNIA

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

## APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

005724 734.00 373.00 SIR 11/21/94

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

Bischoff Lorena Doud

1. Name: Last First Middle

007639 69.08 SIR 373.00 1/17/95

Bischoff Lorena Doud

PERSONAL DATA

2. Other names you have used (include maiden name): -0-

3. Social Security Number
See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any)
141 Duke Ave.

| City | State | ZIP Code | Country |
|---|---|---|---|
| Ventura | CA | 93003 | USA |

5. Telephone Number: Home Work
6. Date of Birth: Mo/Day/Yr
Place of Birth:

7. Sex: ☒ Female ☐ Male

8. Are you a U.S. citizen? ☒ Yes ☐ No
If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If YES, give date previous application was submitted:

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

NON-MEDICAL EDUCATION

| Name | Address | Period of Attendance From (Mo/Yr) | To (Mo/Yr) |
|---|---|---|---|
| Univ. California Santa Barbara | UCSB, SB, CA 93106 | 9/85 | 6/89 |
| | | | |
| | | | |

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

| Course | Yes | No | Name of College or University |
|---|---|---|---|
| Chemistry | ✓ | | U.C. Santa Barbara |
| Physics | ✓ | | " |
| Biology or Zoology | ✓ | | " |

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official sealed transcripts from each school attended.

MEDICAL EDUCATION

CME TRANS

| Name | Address | Place Where Instruction Received | Period of Attendance From (Mo/Yr) | To (Mo/Yr) |
|---|---|---|---|---|
| Wayne State University School of Medicine | 540 E. Canfield Detroit, CA 48201 | WSU School of Med. | 8/89 | 6/93 |
| | | | | |

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

MI007
School Code

| Name of Medical School | Address of Medical School | Exact Date of Issuance |
|---|---|---|
| Wayne State University School of Medicine | 540 E Canfield Detroit, MI 48201 | 6/6/93 |

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

# L1A

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MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification?

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure.

☒ Yes ☐ No

WRITTEN EXAMINATION

| Name | Location | Date | Result |
|---|---|---|---|
| NBME Step 1 | WSU School of Med | 3/1991 | |
| USMLE Step 2 | Stanford Univ. | 9/92 | |
| USMLE Step 3 | Rush Univ. | 5/94 | |
| | | | |

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?
(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs)

☒ Yes ☐ No

POSTGRADUATE TRAINING

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

| Name | Address | Type of Service | Period of Attendance | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| Ventura County Med. Center | 3291 Loma Vista<br>Ventura, CA 93003 | Internship | 7/93 | 7/94 to currently |
| | | | | |
| | | | | |

L9

***QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.***

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program?

Yes No

15. Have you been licensed to practice medicine in any state or country?

Yes No

LICENSE DATA

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed. Please include temporary, limited, or provisional licenses.

| State or Country | License Number | Date of Issuance | Dates of Practice in Issuing Agency's Jurisdiction | |
|---|---|---|---|---|
| | | | From (Mo/Yr) | To (Mo/Yr) |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

If yes, give details below.

Yes No

| State | Date | Charge | Disposition |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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L1B

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MBC USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below.

| State or Country | Date of Denial | Reason for Denial |
|---|---|---|
| | | |
| | | |

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body? You must also list any pending actions or accusations. Yes No

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances such as narcotics or alcohol? Yes No

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances? Yes No

If yes, give details below.

| Violation and Location | Date | Penalty or Disposition |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

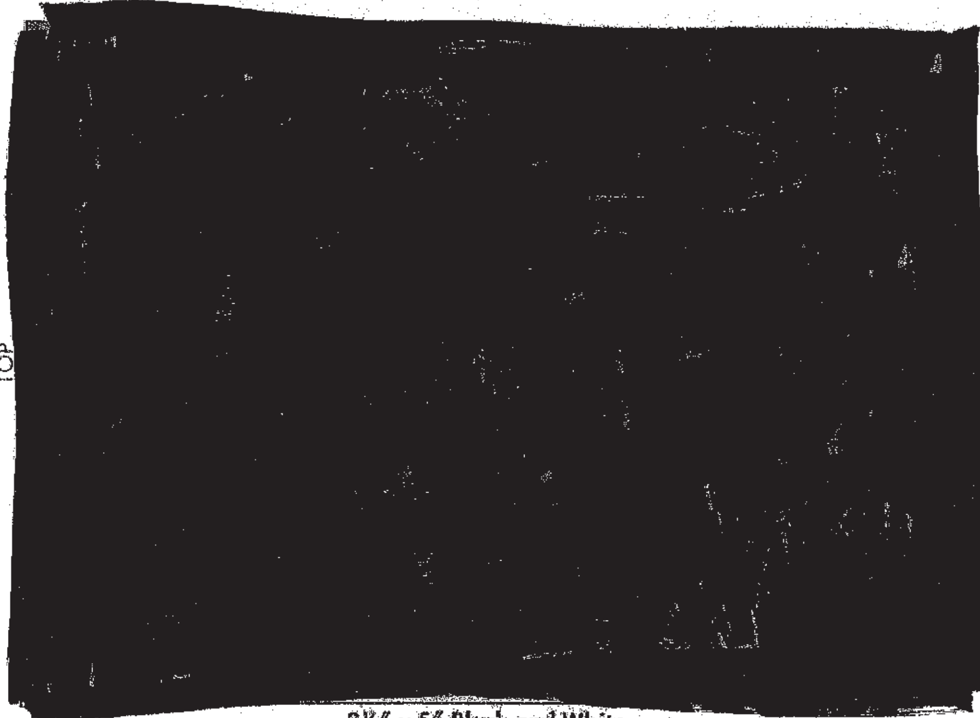
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

| Violation and Location | Date | Penalty or Disposition |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C



TOP

3½" x 5" Black and White

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ______, ______, 19__

my age then being ______ years;

color of hair ______;

color of eye ______;

height ______ ft. ______ in.;

weight ______ lbs.;

identifying marks ______

**NOTE:** All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

NOTARIZATION PORTION

STATE OF California )

COUNTY OF Ventura )

Lorena Doud Bischoff being duly sworn, says She is the person referred to in
PRINT FULL NAME OF APPLICANT

the foregoing application for a physician and surgeon's certificate in California and that She has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

SHe requests that the Division of Licensing, Medical Board of California, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, She authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

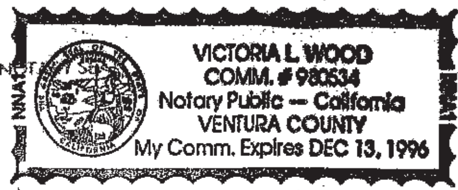
Lorena Bischoff
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 7 day of September, 1994

Signature of Notary Public Victoria L Wood

Address 1000 Town Center, Oxnard, CA

My commission expires ______




L1D

PETE WILSON, Governor

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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

# CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Lorena Doud Bischoff (FULL NAME OF APPLICANT)

of ______ (ADDRESS WHEN ENROLLED) enrolled in Wayne State University (NAME OF MEDICAL SCHOOL)

Detroit, MI (LOCATION) on the 22 day of august (MONTH) 1989 (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 California Santa Barbara (EDUCATIONAL INSTITUTION) 9/85 – 6/89 (DATES)

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

NA (MEDICAL SCHOOL) ______ (TOTAL CREDITS) ______ (DATES)

The undersigned further certifies that the records of this institution show that She attended in this institution --all-- (SPECIFY NUMBER) years of resident instruction of four years (NUMBER OF) 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

[X] She was granted the degree Bachelor/Doctor of Medicine by

OR [ ] __he withdrew from

the above-mentioned medical school on the 3 day of June (MONTH) 1993 ✓

RECEIVED SEP 06 1994 RECORDS OFFICE WSU SCHOOL OF MEDICINE

| | | |
|---|---|---|
| Anatomy | Dermatology | Preventive medicine, including Nutrition |
| Otolaryngology | Embryology | Physical Medicine |
| Obstetrics and Gynecology | Histology | Therapeutics |
| Radiology, including Radiation Safety | Human Sexuality as defined in Section 2090 | Neuroanatomy |
| Tropical Medicine | Medicine | Child Abuse Detection and Treatment |
| Physiology | Surgery, including Orthopedic Surgery | Geriatric Medicine |
| Biochemistry | Urology | Pediatrics |
| Pathology, Bacteriology and Immunology | Psychiatry | Pharmacology |
| Ophthalmology | Neurology | Anesthesia |

Signed and the college seal affixed this 4 day of OCTOBER, 19 94. ✓

BY Sandra J. Driscoll
MS. SANDRA J. DRISCOLL/RECORDER ✓

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.

L2

07A-100-L2 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, *Governor*

**MEDICAL BOARD OF CALIFORNIA**
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

# CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

**To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.**

PART 1: *To be completed by applicant/trainee.*

Last Name Of Trainee: Bischoff First Name: Lorena Middle Initial: D

Current Address: 141 Duke Ave Phone Number:

City: Ventura State: CA Zip Code: 93003

PART 2: *To be completed by facility.*

Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".

Name of Facility: VENTURA COUNTY MEDICAL CENTER

Address of Facility: 3291 LOMA VISTA ROAD VENTURA CA 93003

Name of Program Director: LANYARD K. DIAL, M.D. Phone Number: (805) 652-6228

Signature of Program Director: [signature] Date Signed: 9/23/94

List Categorical Specialty Area of Training Completed by Trainee: FAMILY PRACTICE Date Training Commenced: 7/1/93 Date Training Completed: 6/30/94

CONTINUING IN RESIDENCY THROUGH 6/30/96

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

13 ROTATIONS 4 WEEKS/ROTATION

MEDICINE; ORTHOPEDICS; PEDIATRICS; SURGERY; COMMUNITY MEDICINE; MEDICINE; OB/GYN;

DAY EMERGENCY ROOM; OB/GYN; SURGERY; MEDICINE; SPECIAL ELECTIVE; PEDIATRICS/ICN MEDICINE

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

PART 3: *To be completed by the Director of Medical Education and affixed with the official facility seal.*

| | | | |
|---|---|---|---|
| Name of Director of Medical Education: | LANYARD K. DIAL, M.D. | Phone Number: | (805) 652-6228 |
| Facility Name: | VENTURA COUNTY MEDICAL CENTER | Date Form Completed: | 9/23/94 |
| Facility Address: | 3291 LOMA VISTA ROAD | | |

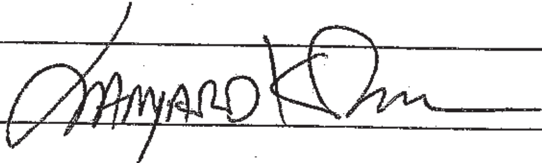
City: VENTURA State: CA Zip Code: 93003

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

*Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.*

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

Signature of Director of Medical Education:



Date Signed: SEPTEMBER 23, 1994

PLEASE SEE ATTACHED LETTERS ✓OK

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

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY PETE WILSON, *Governor*

# MEDICAL BOARD OF CALIFORNIA

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

## CERTIFICATION STATEMENT

This is to certify that Lorena Bischoff (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on 7/1, 1993 and is expected to be completed on 6, 1996 in Family Medicine (Type of Training)

at Ventura County Medical Center (Name and Address of Facility) OK
3291 Loma Vista Ventura CA 93003

**(AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY PUBLIC SEAL)**

PLEASE SEE ATTACHED LETTERS ✓

*I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.*

LANYARD K. DIAL, M.D.
Type or print name of Director of Medical Education

[signature]
Signature of Director of Medical Education

SEPTEMBER 23, 1994
Date

(805) 652-6228
Phone Number

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

**L9**

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

**STATE DEPARTMENT OF CONSUMER AFFAIRS**
**INTERNET CASHIERING SYSTEM**
**MEDICAL BOARD OF CALIFORNIA**
**SUPPLEMENTAL INFORMATION REPORT**
**From Date:** 06/14/2012 **To Date:** 06/14/2012

**ATRISUPPINF**

**24-MAR-16 11:42:00**

**Person Id :** 619013 **Name :** Russo,Lorena

| 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? | |

**Total Questions Asked For Person :** 619013 8

(DO NOT DETACH)

**Medical Board of California – Physician's and Surgeon's Initial Renewal**

| LICENSEE NAME | LICENSE NO. | EXPIRATION DATE | AMOUNT DUE NOW | AMOUNT DUE IF POSTMARKED AFTER SEPTEMBER 30, 2014 |
|---|---|---|---|---|
| **RUSSO, LORENA B** | **G81050** | **08/31/14** | **$820.00** | **$898.00** |

**LICENSEE MUST CHECK CORRECT BOXES**

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [ ] Financial Interest Statement

"D" **SIGNATURE REQUIRED**

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature ____________ Date 6/13/14

**ENTER YOUR PHONE NUMBER FOR REFERENCE:**

630107000007000060008105070108311400082000000089800

**CHANGE OF MAILING ADDRESS** **RUSSO, LORENA B** **G81050**

06162014 20001323 20010014

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip -

PO Box (if used, must provide a confidential physical street address, above)

City State Zip -