STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

3/19 #112131

GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that LASHA KIM PIERCE (FULL NAME OF APPLICANT) of Fairfield, California (ADDRESS WHEN ENROLLED) enrolled in University of California, Irvine College of Medicine (NAME OF MEDICAL SCHOOL) Irvine, California (LOCATION) on the 6th day of September (MONTH) 19 94 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).*

San Francisco State University, San Francisco, CA (EDUCATIONAL INSTITUTION) 8/89 - 9/93 (DATES)

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

MEDICAL SCHOOL ______ TOTAL CREDITS ______ DATES ______

The undersigned further certifies that the records of this institution show that she attended in this institution four (SPECIFY NUMBER) years of resident instruction of 32 - 46 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that:

[X] She was granted the degree ~~Bachelor~~/Doctor of Medicine by OR [ ] he withdrew from

the above mentioned medical school on the 19th day of June (MONTH), 19 99.

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology

Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency

Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Family Medicine**
Spousal or Partner Abuse Detection & Treatment***

* 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.**

** 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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 27th day of February 2001

BY [signature]
PRESIDENT, SECRETARY, DEAN

L2

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

RECEIVED IN CASHIERS

01 MAR 16 AM 11:23

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

105140
833.003

APPLICATION FOR PHYSICIAN AND SURGEON'S LICENSURE

Please 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 as per instructions.
Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

1. Name: Last: PIERCE First: LASHA Middle: KIM

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

3. Social Security Number◆

4. Address: Number and Street/Rural Route (include apartment number, if any): 3483 SPRINGFIELD DR.

5. Sex: ☒ Female ☐ Male

City: FAIRFIELD State: CA Zip Code: 94533 Country: USA

6. Telephone Number:
Home:
Work:

7. Date of Birth: Mo/Day/Yr
Place of Birth:

8. California Driver's License Number, if applicable:
NUMBER EXPIRATION

9. Are you a U.S. citizen? ☒ Yes ☐ No
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

11A. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
HOWARD UNIVERSITY	2400 - 6th St, N.W. WASHINGTON DC 20059	8/88 - 6/89
SAN FRANCISCO STATE UNIVERSITY	1600 HOLLOWAY AVE SAN FRANCISCO CA 94132	8/89 - 6/93

11B. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	X		SAN FRANCISCO STATE UNIVERSITY
Physics	X		LANEY COLLEGE
Biology or Zoology	X		SAN FRANCISCO STATE UNIVERSITY

12. List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and 2) an original medical diploma and a photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
UC - IRVINE	P.O. BOX 4089 IRVINE CA	IRVINE	8/94 - 6/99	MD

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may submit in lieu of the original diploma an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
UNIVERSITY OF CALIFORNIA - IRVINE	CALIFORNIA	6/19/99

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

CA 015
School Code

L1A

07A-100 (Rev. 3/99)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, or LMCC?

☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO LICENSURE.

Examination	Location	Date	Result
USMLE STEP I	IRVINE CA	6/1997	
USMLE STEP II	IRVINE CA	8/1998	
USMLE STEP III	OAKLAND CA	2/2/01 - 2/3/01	

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

☐ Yes ☒ No

IF YES, LIST STATE OR COUNTRY, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

License Data

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?

☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Type of Service	Dates of Attendance
KAISER HOSPITAL	2425 GEARY BLVD SAN FRANCISCO CA	OB/GYN RESIDENT	6/27/99 - 6/26/00

Postgraduate Training

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program?

Yes No

16. 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 or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? 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

License Data

ONLY
License Data

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? Yes No
IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? Yes No
IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): ______

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

Violation and Location	Date	Penalty or Disposition

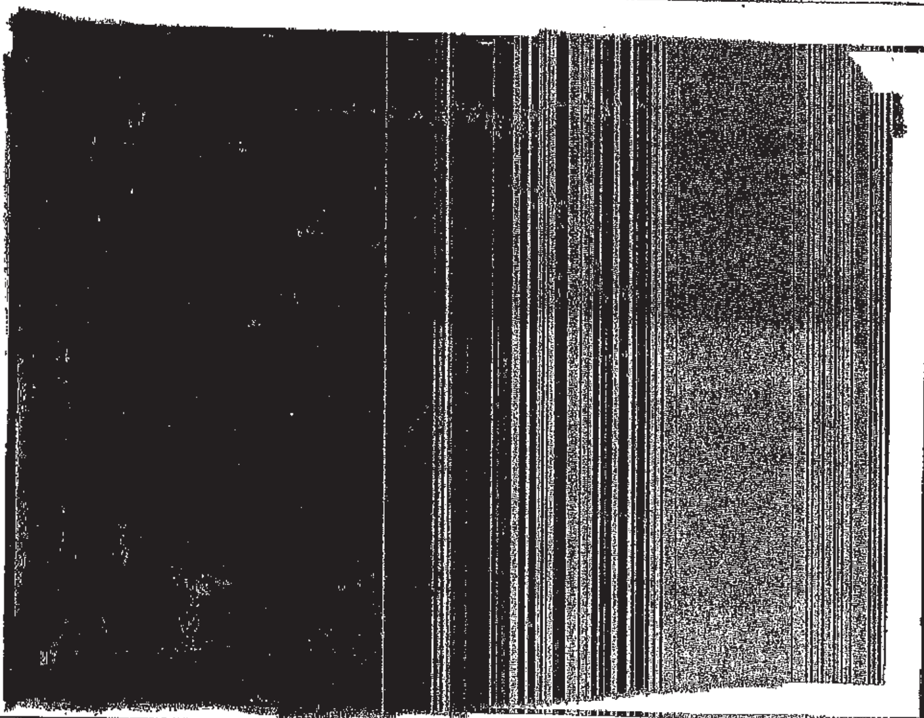


PHOTO DECLARATION

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 21 years;

my color of hair ______;

my color of eyes ______;

my height ____ ft. ____ in.;

my weight ______ lbs.;

and identifying marks are

______

Signature of Applicant:

Notice: All items in this application are mandatory; none are voluntary. 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 or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.

STATE OF California)

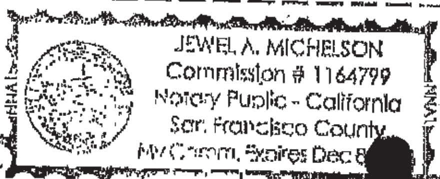
COUNTY OF San Francisco)

The applicant, Lasha Kim Pierce, being first duly sworn upon ~~his~~/her
PRINT FULL NAME OF APPLICANT

oath deposes and says: that ~~he~~/she is the person herein named subscribing to this application: that ~~he~~/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that ~~he~~/she is 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 the applicant is aware and that the applicant is 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 my 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 further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: ______
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 23rd day of February, 19 2001



NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

2425 Geary Blvd, San Francisco CA
ADDRESS

My commission expires 12-08-01

07A-100 (Rev. 3/99)

L1D

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

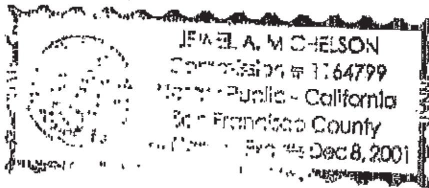
This is to certify that LASHA K. PIERCE
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on

06/27, 19 99 and is expected to be completed

on 06/30 2003 in Obstetrics and Gynecology
Month Day Year (Type of Training)

at Kaiser Foundation Hospital
2425 Geary Blvd., San Francisco, CA 94115
(Name and Address of Facility)



AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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."

Aileen M. Dillon, M.D.
(Type or print name of Director of Medical Education)

Aileen M. Dillon MD
(Signature of Director of Medical Education)

AMD 2/26/01
Aileen M. Dill 2/26/2001
(Date)

SUBSCRIBED AND SWORN TO BEFORE ME
THIS 26th DAY OF February 19 2001
BY Aileen M. Dillon
Jewel A. Michelson
NOTARY PUBLIC

(415) 202-3034
(Telephone Number)

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/CCME Postgraduate Training."

L4

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

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.

PART 1: To be completed by the applicant/trainee

Last Name of Trainee	First Name	Middle Initial
PIERCE	LASHA	K.

Current Address:	Social Security Number
3483 SPRINGFIELD DR.	

City	State	Zip Code	Telephone Number:
FAIRFIELD	CA	94533	

PART 2: To be completed by the facility. ... above and whose photograph is attached to this form ... the following information is provided to certify ... PLEASE SEE THE REVERSE ...

Name of Facility	Address of Facility
Kaiser Foundation Hospital	2425 Geary Blvd., San Francisco, CA 94115

Name of Program Director:	Telephone Number:
Robin Field, M.D.	(415) 202-3034

Signature of Program Director	Date Signed:
[signature] OK	26 Feb 01

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Obstetrics and Gynecology	06/27/99	06/26/00

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the Director of Medical Education ...

Name of the Director of Medical Education:	Facility Name:
Aileen M. Dillon, M.D.	Kaiser Foundation Hospital

Facility Address:
2425 Geary Blvd.

City	State	Zip Code	Telephone Number:
San Francisco,	CA	94115	(415 202-3034

PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

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:
Aileen M. Dillon	2/26/01

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

SUBSCRIBED AND SWORN TO BEFORE ME

THIS 26th DAY OF February 19 2001

BY Aileen M. Dillon

Jewel A. Michelson
NOTARY PUBLIC

JEWEL A. MICHELSON
Commission # 1164799
Notary Public - California
San Francisco County
My Comm. Expires Dec 8, 2001

7A-M... (Rev. ...)

L3A

RETURN THE ENTIRE FORM TO THE RETURN ADDRESS ON THE BACK. MAKE A PHOTOCOPY FOR YOUR RECORDS.

PART 3 — Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body; or, have you been convicted of any crime in any state, the U S A and its territories, military court or a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

License Renewal Application
Physician and Surgeon

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

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: [signature] DATE: 7/9/12

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 10/30/12
A 75116	09/30/12	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET ____________________

CITY ____________ STATE ______ ZIP ______

PHONE NUMBER ( )

ACTIVE LASHA KIM PIERCE
2615 KINGSLAND AVENUE
OAKLAND CA 94619

G. FINANCIAL INTEREST STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST, OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

[signature]
Signature required here

OVER

630101000001000020007511640109301200080800000088600

07202012 10001725 10010018

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address

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

SMBCLS 02/28/05

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 OCTOBER 30, 2014
PIERCE, LASHA K	**A75116**	**09/30/14**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" ☑ Completed Continuing Education
- "E" ☐ Change of Address (fill in reverse side)
- "I" ☐ Conviction Disclosure – Yes
- "J" ☑ 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 [signature] Date 7/2/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630101000001000020007511640109301400082000000089800

CHANGE OF MAILING ADDRESS **PIERCE, LASHA K** **A75116**

07102014 20001437 20010015

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