Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	
Application Date:	**12/30/2013 (mm/dd/yyyy)**

Application Questions

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**N**

Personal Detail

First Name:	**Lisa**
Middle Name:	**Leilani**
Last Name:	**Bayer**
Birthdate:	
Gender:	**Female**
Social Security Number:	

Addresses

License Related Addresses

License Specific Public/Mailing Address (Required)

Address:	**3181 SW Sam Jackson Park Rd** **Mail code UNH 50** **PORTLAND, OR** **97239-3011** **US**
Phone Number:	
Extension:	
E-mail Address:	
Home Number	
Cell Number	

Personal Information

Country of Birth:	**United States**
US State of Birth:	IL ? !

City of Birth:

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?

11. Have you previously held a Physician's and Surgeon's License in California? **No**

If you answered "Yes" to 11, please provide the expiration date: **(mm/dd/yyyy)**

Exam Questions

12. Have you ever been found to have engaged in irregular behavior during an examination?

13. Have you ever been subject to an investigation by an examination entity?

14. Are you certified by the Educational Commission for Foreign Medical Graduates?

Certificate issue date **(mm/dd/yyyy)**

Examinations 1

Examination: **United States Medical Licensing Examination (USMLE) Step 1**

Exam Date: **06/2006 (mm/yyyy)**

Exam Result:

Examinations 2

Examination: **United States Medical Licensing Examination (USMLE) Step 2CK**

Exam Date: **12/2007 (mm/yyyy)**

Exam Result:

Examinations 3

Examination: **United States Medical Licensing Examination (USMLE) Step 2CS**

Exam Date: **10/2007 (mm/yyyy)**

Exam Result:

Examinations 4

Examination: **United States Medical Licensing Examination (USMLE) Step 3**

Exam Date: **05/2009 (mm/yyyy)**

Exam Result:

Medical Education

18. Did you ever take a leave of absence during medical school?	
19. Were you ever placed on probation?	
20. Were you ever disciplined or placed under investigation?	
21. Were any negative reports ever filed by your instructors?	
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	

Postgraduate Training

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada?	**Yes**

Postgraduate Training

State/Province:	**Oregon**
Program Facility Name	**Oregon Health & Science University**
Specialty:	**Ob/Gyn**
Training Start Date:	**07/01/2008** (mm/dd/yyyy)
Training End Date:	**06/30/2012** (mm/dd/yyyy)
Program Location Address:	**3181 SW Sam Jackson Park Road Portland, OR 97239**

PG Training Unusual Circumstances

24. Have you ever received partial or no credit for a postgraduate training program?	
25. Have you ever taken a leave of absence or break from your training?	
26. Have you ever been terminated, dismissed or expelled from a program?	
27. Have you ever resigned from a program?	
28. Were you ever placed on probation for any reason?	
29. Were you ever disciplined or placed under investigation?	
30. Were any incident reports ever filed by instructors?	

31. Were any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?	
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	
Medical License	
33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province?	**Yes**
Medical License Information 1	
State/Province	**Oregon**
License Number:	**MD157469**
Issue Date:	**03/12/2012 (mm/dd/yyyy)**
Expiration Date:	**12/31/2015 (mm/dd/yyyy)**
Medical License Information 2	
State/Province	**Washington**
License Number:	**MD 60274374**
Issue Date:	**03/21/2012 (mm/dd/yyyy)**
Expiration Date:	**01/30/2015 (mm/dd/yyyy)**
ABMS Certification	
34. Are you currently certified by a Member Board of the American board of Medical Specialties?	**No**
Expiration Date:	**(mm/dd/yyyy)**
Expiration Date:	**(mm/dd/yyyy)**
35. Has your certification ever been suspended or revoked?	
36. Is there any action currently pending against you?	
DEA Questions	
37. Are you currently registered with the Drug Enforcement Agency (DEA)?	
38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	

39. Have you ever entered into any arrangement, agreement, or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?

DEA Certification

DEA Number:

State of Issue: **Oregon**

Expiration Date: **07/31/2014 (mm/dd/yyyy)**

Malpractice History

40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?

41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?

Disciplinary History

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?

43. Have you ever been denied a license to practice medicine?

44. Is any denial pending against you?

45. Have you ever had any license to practice medicine subjected to any disciplinary action?

46. Is any disciplinary action pending against any of your licenses to practice medicine?

47. Have you ever surrendered a license to practice medicine?

48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?

49. 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?

50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?

51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?

52. Is any disciplinary action pending against your hospital or staff privileges?

53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?

Criminal Record History

55. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?

56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older: have you had a conviction that was set aside or later expunged from the record of the court?

57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

58. Are you a registered Sex Offender?

Practice Impairment

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?

Family Physician Training Program Voluntary Fee

Voluntary Fee: No

Attachments

Lisa_Bayer CV 10.2013.pdf

Fees

Application Fee	**$442.00**
Department of Justice (DOJ) Fee	**$32.00**
Federal Bureau of Investigation (FBI) Fee	**$17.00**
Initial License Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$1299.00**

Applications are not considered submitted for processing until payment is received.

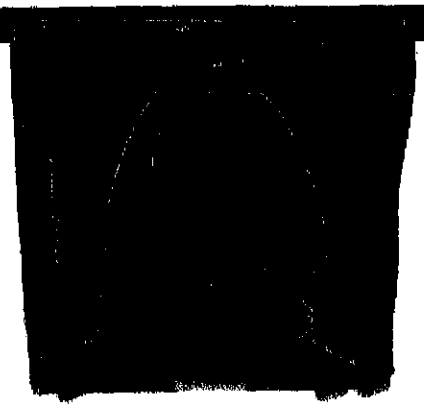
Attestation

I attest 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 authorized all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, stated, 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.

Signature: Date:

PHOTOGRAPH



Notice: All items in this application 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 licensing 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.

MBC Use Only

Photograph ☑

DECLARATION

Applicant Name & DOB ☑

The applicant, Lisa Leilani Bayer _____
Please print full name (First, Middle, Last)

Date of Birth (mm/dd/yyyy)

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), or 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, alcohol and/or substance 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, 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.

Applicant Signature & Date ☐

SIGNATURE: _____ **DATE:** 12/30/2013

NOTARY SECTION

Applicant Signature ☐

SIGNATURE OF APPLICANT: _____
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

State of OREGON

County of Multnomah

Applicant Name & Notary Date ☑

Subscribed and sworn to (or affirmed) before me on this 31st day of December, 2013,

by, Lisa L. Bayer proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL SEAL
VALERIE ANGELA FORSTER
NOTARY PUBLIC-OREGON
COMMISSION NO. 477283
MY COMMISSION EXPIRES MARCH 28, 2017

Notary Signature & Seal ☐

L1F

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF MEDICAL EDUCATION

Check one: ☑ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last	First	Middle
Bayer	*Lisa*	*Leilani*

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
		University of Illinois at Chicago

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Name of Medical School	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE
State/Province/Country	CHICAGO IL
Did the applicant complete an English Language program?	☒ Yes ☐ No

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). **The standard duration of the curriculum at this institution is 4 years.**

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology, and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventative Medicine, including Nutrition
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***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994
** ONLY applicable to medical students who graduated from medical school on or after June 30, 1999
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000

Date the applicant enrolled in medical school:	05/16/2004
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	05/12/2008
Date the applicant withdrew from medical school (if applicable):	__/__/____

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

1. Did this applicant ever take a leave of absence from his/her medical education?	☐
2. Was this applicant ever placed on probation?	☑
3. Was this applicant ever disciplined or placed under investigation?	☐
4. Were any negative reports regarding this applicant ever filed by Instructors?	☑
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	☐

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

SUSAN HUHNDORF — DIRECTOR, RECORDS & REGISTRATION

PRINTED NAME OF SCHOOL OFFICIAL — TITLE OF SCHOOL OFFICIAL

SIGNATURE OF SCHOOL OFFICIAL — 1/10/14 DATE

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. 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.

MBC Use Only
Medical School Information
Dates of Attendance
Unusual Circumstances
Signature & Seal

L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

07A-100 Revised 8/2013

Mailed 1/31/14

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA
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.

Check one: ☑ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly — APPLICANT INFORMATION			MBC Use Only
NAME: Last *Bayer*	First *Lisa*	Middle *Leilani*	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation	Personal Data ☐
		University of Illinois at Chicago	

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form prior to 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 applicant referenced above has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. ***The completed form must be mailed directly from the program to the Board.***

Training Information

Facility Name	Oregon Health & Science University		☐
Facility Address	3181 SW Sam Jackson Park Rd, L466		☐
Specialty	OB/GYN	**ACGME 10-digit Program #** http://www.acgme.org/adspublic	☐ ☐
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2008	End Date (or anticipated completion date): 06/30/2012	☐ ☐

UNUSUAL CIRCUMSTANCES

1. Did the applicant receive partial or no credit for any postgraduate training year?		☐
2. Did the applicant ever take a leave of absence or break from his/her training?	I	☐
3. Was the applicant ever terminated, dismissed or expelled?		☐
4. Did the applicant ever resign?		☐
5. Was the applicant ever placed on probation?		☐
6. Was the applicant ever disciplined or placed under investigation?		☐
7. Were any incident reports regarding this applicant ever filed by instructors?		☐
8. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?		☐
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?		☐

***Program Director*: Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

L3A

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

GENERAL MEDICINE TRAINING REQUIREMENT

MBC Use Only

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 had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

General Medicine

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☐ Yes ☐ No

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant 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. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Karen Adams — PRINTED NAME OF PROGRAM DIRECTOR

adamsk@ohsu.edu — Email Address

Program Director's Signature & Date

SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable) — DATE: 1/5/14 — Phone Number: 503.494.3106

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.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

Program Director's Signature

SIGNATURE OF PROGRAM DIRECTOR: _____ (Please sign full name in presence of notary)

State of Oregon

County of Multnomah

Subscribed and sworn to (or affirmed) before me on this 24th day of January, 2014

by, Karen E. Adams, MD (Print program director's name) proved to me on the basis of satisfactory evidence

to be the person who appeared before me.

Notary Signature & Seal

SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

OFFICIAL SEAL
VALERIE ANGELA FORSTER
NOTARY PUBLIC-OREGON
COMMISSION NO. 477283
MY COMMISSION EXPIRES MARCH 28, 2017

Hospital Seal

L3B

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

Thank you for using the BreEZe System to submit your application.

Name:	BAYER, LISA LEILANI
Transaction Date:	01/04/2016 10:02
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	130203
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	820.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**130203**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**01/04/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**LISA**
Middle Name:	**LEILANI**
Last Name:	**BAYER**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

Warning:	**In order to protect your privacy and identity, address will not be displayed.**

Questions

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**
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - 1-9 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 97239 County: OUT OF STATE**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**3 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Decline to state**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - No**

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**

Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

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

Signature: Date: