STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

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MEDICAL BOARD
OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

2004 MAR 19 AM 11:16

2004 MAR 23 AM 9:40

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

UU0213 830.00 3/22/04

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.

MBC USE ONLY

1. NAME: Last: Prager | First: Sarah | Middle: Ward

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

3. U.S. Social Security Number*

4A. (PUBLIC ADDRESS: will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.
Obstetrics, Gynecology + Reproductive Sciences / UCSF / San Francisco General Hospital / 1001 Potrero Ave. 6D-15
City: San Francisco | State: CA | Zip Code: 94110 | Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]
170 Coronado Circle
City: Santa Barbara | State: CA | Zip Code: 93108 | Country: USA

5. Telephone Number:
Home:
Work:

6. California Driver's License Number (optional):
NUMBER
EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth:

8. Sex: ☐ Male ☒ Female

9. Are you a U.S. citizen? ☒ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California?
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. ☐ Yes ☒ No

11. List the names and locations 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. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
Princeton University	Princeton, New Jersey USA	9/1989 - 6/1993
University of Washington	Seattle, Washington USA	9/1994 - 6/1995

12. List the names and locations 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 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
UT Southwestern	Dallas, Texas USA	8/1996 - 6/2000	M D

DOCTOR OF MEDICINE DEGREE as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
University of Texas, Southwestern	5323 Harry Hines Blvd Dallas, TX 75390-9096	6/3/2000

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS
Disclosure of your U.S. social security number 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 will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family 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 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.

MBC USE ONLY
School Code: 1900

L1A

07A-700 Web (Revised 11/03)

Personal Data

Pre-Medical Education

Medical Education

L2 Trans

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or MCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
USMLE Step I	6/1998	
USMLE Step II	9/1999	
USMLE Step III	7/2001	

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
Vermont	060-0002091	05/14/2003	6/23/2000 – 6/22/2004	☒ training license
				☐
				☐
				☐

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

Other Professional Licenses

IF YES: PROFESSION: _____ LICENSE NO.: _____ JURISDICTION: _____

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

Yes ☐ No ☒

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As 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	Categorial Specialty Area	Dates of Attendance	
Fletcher Allen	111 Colchester Avenue	OB/Gyn	6/23/00 – 6/22/04	☒
				☐
				☐
				☐

QUESTIONS 16B through 23:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes ☐ No ☒

NAME OF APPLICANT: Sarah Ward Prager

DATE OF BIRTH:

L1B

MBC USE ONLY

License Date

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. 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?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A)	Yes	No	☐
17(B)	Yes	No	☐
17(C)	Yes	No	☐

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. 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?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No ☑

19. 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, territory, country, or U.S. federal jurisdiction, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No ☑

20. Have you ever voluntarily surrendered a license to practice medicine or any other 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?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No ☑

21. 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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION. Yes No ☑

22. 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?

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW: Yes No ☑

- ☐ 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.

FOR ALL OF THE BELOW, 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.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23(A)	Yes	No	☐
23(B)	Yes	No	☐

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: Sarah Ward Prager

DATE OF BIRTH:

L1C

Top of Photo (Head)

Bottom of Photo (Shoulders)

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 Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF Vermont ✓

COUNTY OF Chittenden

The applicant, Sarah Ward Prager (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 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 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 OF APPLICANT: Sarah Ward Prager ✓
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 15 day of March 2004 ✓
MONTH YEAR

NOTARY SEAL

Amy R Rigg
SIGNATURE OF NOTARY PUBLIC

Burlington, Vermont
ADDRESS

My commission expires 2/10/07

07A-100 Web (Revised 11/03)

L1D

3/22/04

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that Sarah Ward Prager ; _____ ; _____
FULL NAME OF APPLICANT U.S. SOCIAL SECURITY NO. DATE OF BIRTH-MM/DD/YYYY

enrolled in University of Texas South Western ✓ Dallas, Texas
NAME OF MEDICAL SCHOOL LOCATION

on the 19th day of August 1996 and was granted the following credits on enrollment:
MONTH YEAR

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 the applicant attended in this institution 4 NUMBER OF YEARS

years of resident instruction of 40 - 48 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 the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the 2 day of June, 2000 ✓
MONTH YEAR

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
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
Spousal or Partner Abuse Detection & Treatment**
Family Medicine***
Pain Management and End-of-Life Care****

* 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.
** 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.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW. ✓

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 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.

Signed and the school seal affixed this 19th day of March 2004
MONTH YEAR

BY: _____, Asst. to the Registrar
PRESIDENT, DEAN, OR REGISTRAR

L2

07A-100-L2 (Rev. 11-26-03)

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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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education 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.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
Prager	Sarah	W

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number: Home: / Work:

Current Address: 189 Juniper Drive

City	State	Zip Code
South Burlington	VT	05403

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 completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
Fletcher Allen Health Care	111 Colchester Avenue, Burlington, VT 05401
Name of Program Director: Marjorie Meyer	Telephone Number: (802) 847-5214
Signature of Program Director: OK 4/19/04	Date Signed: 5/16/04
List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced: 6/23/2000
	Date Training Completed: 6/22/2003

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 and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Maureen Loeffler	Fletcher Allen Health Care
Address of Facility: 111 Colchester Avenue	
City: Burlington / State: VT / Zip Code: 05401	Telephone Number: (802) 847-5162

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *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. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY 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 RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:	Date Signed:
Maureen Loeffler	3/16/04

L3A

07A-100-L3 (Revised 11/03)

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ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/ RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that Sarah Ward Prager ; _____
(Name of Applicant) (U.S. Social Security Number)

_____ is in an approved ACGME/RCPSC postgraduate training position that
DATE OF BIRTH-MM/DD/YYYY

commenced on June (MONTH) 23 (DAY) 2000 (YEAR) and is expected to be completed on

June (MONTH) 22 (DAY) 2004 (YEAR) in Obstetrics / Gynecology (Type of Training)

at Fletcher Allen Health Care
(Name and Address of Facility)

OK

ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Director of Medical Education 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.

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

Maureen Loeffler
(Type or print name of Director of Medical Education)

Maureen Loeffler, Director GME
(Signature of Director of Medical Education)

March 15, 2004 (Date)

802-847-4255 (Telephone Number)

OFFICIAL HOSTPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.

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

L4