STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

BOARD OF MEDICAL QUALITY ASSURANCE
9 Mar 88 1625

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

010715 00860 595.60 004102 45.00 10/89

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.

1. Name: Last: Bowie First: Lisa Middle: Ann
2. Other names you have used: N/A
3. Address: Number and Street/Rural Route (include apartment number, if any): 2828 Pavan Ct.
   City: San Jose State: CA ZIP Code: 95148 Country: U.S.A.
4. Telephone Number: Home Work
5. Date of Birth: Mo/Day/Yr 6/17/59
6. Sex: [X] Female [ ] Male
7. Are you a U.S. citizen? [X] Yes [ ] No
   Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA document, or license to practice medicine.
8. Have you ever filed an application in California? [ ] Yes [X] No
   If YES, give date of previous application:
9. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Yale University	New Haven, CT	8/81	5/83
U.C. Santa Cruz	Santa Cruz, CA	9/77	6/81

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

Course	Yes	No	Name of College or university
Chemistry	X		U.C. Santa Cruz
Physics	X		U.C. Santa Cruz
Biology	X		U.C. Santa Cruz
Zoology		X	

NON MEDICAL EDUCATION

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

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	Grad	Transfer
DREW/UCLA	Los Angeles, CA	Los Angeles, CA	8/83	6/85	☐	☐
			8/85	6/88	☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance
UCLA		5-21-88

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
National Board E	S.F.	9/85	
National Board I	Palo Alto	6/86	
National Board I	Palo Alto	9/86	
National Board II	Los Angeles	9/87	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☐ Yes ☒ No If U.S.:

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

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☒ No

If YES, list state or country, license number, date issued and dates all practice in that agency's jurisdiction (or each). Submit a letter of Good Standing from each state in which you are licensed or have been licensed.

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

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BMQA USE ONLY

16. Has any disciplinary action ever been 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:

State	Date	Charge	Disposition

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?

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

If yes, please explain on a separate sheet of paper.

19. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?

If yes, please explain on a separate sheet of paper.

20. [illegible] were you in the past, addicted to controlled substances, such as narcotics or alcohol?

21. 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, or to drug addiction? ☐ Yes ☒ No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

22. 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.)

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

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[redacted]

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 ______

my age then being ______ years;

color of hair ______

color of eyes ______

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. 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.

STATE OF ______ }

COUNTY OF ______ }

______ being duly sworn, says ___he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that ___he 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.

___He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, ___he 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.

[signature]
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this *4th* day of *March*, 19*89*

Signature of Notary Public [signature]

Address *1960 Storey Rd, San Jose, 95122*

SEAL

OFFICIAL SEAL
ROBERT L. JOHNSON
NOTARY PUBLIC CALIFORNIA
SANTA CLARA COUNTY
My Comm. Expires Dec. 20, 1991

My commission expires ______

L1D

07A-100

RECEIVED
89 JUL 20 PM 12:06

JUL 14 1989

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

DIVISION OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825 (916) 920-6371

DIVISION OF MEDICAL EDUCATION

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

This certifies that Lisa Ann Bowles
(FULL NAME OF STUDENT)

of Los Angeles (HOME TOWN AND STATE) enrolled in Charles R. Drew University of Medicine and Science/David Geffen School of Medicine

1621 E. 120th Street, LA Ca 90059 (ADDRESS) on the 1st day of Medicine (MONTH) September 1983 (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 2089).

U.C. Santa Cruz (EDUCATIONAL INSTITUTION) 9/77 – 6/81 (DATES)

Advanced Credits. Credit previously obtained at an approved medical school:

N/A (MEDICAL SCHOOL) (TOTAL UNITS) (DATE)

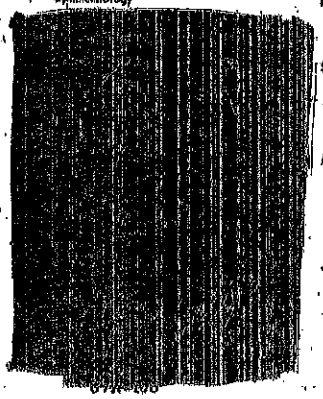
The undersigned further certifies that the records of this institution show that she attended this institution 40 (TOTAL NUMBER) courses of resident instruction of 143 (NUMBER OF DAYS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

☒ she was granted the degree Bachelor/Doctor of Medicine by

☐ she withdrew from

the above mentioned medical school on the 21st day of May (MONTH) 1989

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 2099
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuromuscular
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia



Signed and the college seal affixed this 17 day of July, 19 89.

by Alice Faye Singleton, MD, MPH (SIGNATURE OF OFFICIAL)
Assistant Dean for Student Affairs

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

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1426 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825 (916) 920-6411

BOARD OF MEDICAL QUALITY ASSURANCE

'89 SEP 11 AM 9:37

LICENSING DIVISION

Sep 9 12 58 PM '89

CERTIFICATE OF COMPLETION OF ACGME 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 below. Please type or print.

This is to certify that Lisa D. Bodnar
(NAME OF APPLICANT)

a graduate of UCLA / Drew 1984 MD
(NAME OF MEDICAL SCHOOL)

commenced postgraduate training in Santa Clara Medical Center Family Practice Residency Program
(NAME AND ADDRESS OF FACILITY)

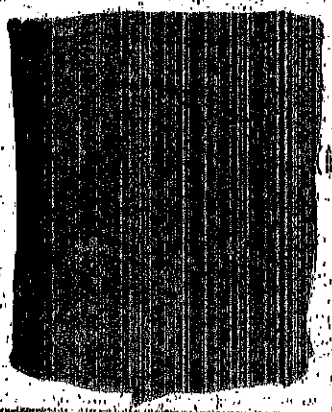
751 South 14th Street #1060, San Jose, CA 95112

on July 1, 1988 and completed such training

on June 30, 1989 This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If combined, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and obstetrics would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Medicine	4 months
Obstetrics	2 months
Family Medicine	1 month
Surgery	2 months
Pediatrics	2 months
Emergency	1 month



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 was invited to an approved ACGME or CCME program position.

NAME Robert M. Norman, M.D.
(DIRECTOR OF MEDICAL EDUCATION)

(AFFIX SEAL OF FACILITY OR BOARD APPROVED)

ADDRESS 751 North 14th Street #1060

San Jose, CA 95112

PHONE NUMBER (408) 977-4807

DATE August 24, 1989

SIGNATURE [signature]

L3

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

APPLICATION FOR EXAMINATION AND UPDATE

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 including Form 17. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. This request is made in connection with an application now on file with this Board for:
   - ☐ A. Permission to take the following examination:
     - ☐ written examination
     - ☐ reciprocity written examination
     - ☐ oral and clinical examination
   - ☐ B. Update of my application

2. Name — Last: Bowler — First: Lisa — Middle: Ann

3. Other names you have used:

4. Address: Number and Street/Rural Route (include apartment number, if any): 2828 PAVAN CT

City: San Jose — State: CA — ZIP Code: 95148 — Country: USA

Telephone Number: Home: — 4. Date of Birth: Mo./Day/Yr.

7. Have you been licensed to practice medicine in any state or country? ☐ Yes ☐ No

If YES, list each of 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.

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

8. Has any disciplinary action ever been 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:

State	Date	Charge	Disposition

9. 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?

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

10. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

If yes, please explain on a separate sheet of paper.

11. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?

If yes, please explain on a separate sheet of paper.

07A-49 (Rev. 1/88)

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12. Are you now or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

13. 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, or to drug addiction?

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

14. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States or country? (except violations of traffic laws resulting in fines of $75.00 or less.)

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to submit a [illegible] Penal Code or under any other provision of law.

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 _____

my age that being _____ years

color of hair _____

color of eyes _____

height _____ ft. _____ in.

weight _____ lbs.

identifying marks _____

_____

_____

_____

State of California

County of Santa Clara

Lisa Ann Bouie being duly sworn, says: She is the person referred to in 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.

Lisa Ann Bouie
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 11th day of July, 1988.

(SEAL)

OFFICIAL SEAL
M. E. FLORES
NOTARY PUBLIC - CALIFORNIA
SANTA CLARA COUNTY
My Comm. Expires Nov. 28, 1991

Signature of Notary Public M. E. Flores

Address 1960 Story Rd.

My commission expires 11-28-91

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411

OCT 16 4 11 M 89

CERTIFICATION STATEMENT

This is to certify that Lisa A. Bonsit (Name of Physician) is in an ACGME/COME postgraduate training position that commenced on 6 1988 and is expected to be completed on 6 1991 in Family Practice (Type of Training) at 25 North 14th Street Family Practice Residency San Jose, CA 95112 (408) 977-4507 (Name and Address of Facility)

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

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

Robert Norman MD
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

Robert Norman MD
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

10/4/89
DATE

(408) 977-4507
PHONE NUMBER

CMA-71 (3-87)

L9

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/02/2013 **To Date:** 07/02/2013

ATRISUPPINF

07-JUN-17 14:19:56

Person Id : **Name :** Bowie,Lisa

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.	YES
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?	NO

Total Questions Asked For Person : 8

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:	BOWIE, LISA ANN
Transaction Date:	06/24/2015 16:00
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	46634
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:	**46634**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**06/24/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**LISA**
Middle Name:	**ANN**
Last Name:	**BOWIE**
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.**

Confidential Address

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 - 10-19 Hours**
	Other - 1-9 Hours
	Patient Care - 20-29 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95126 County: SANTA CLARA**
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	**Family Medicine - Secondary**
Board Certifications	**None**
Postgraduate Training Years	**5 Years**
Cultural Background	**Other Hispanic**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No
E-mail:	

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: