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

MEDICAL BOARD OF CALIFORNIA

1430 HOWE AVENUE, SUITE 54, SACRAMENTO, CA 95825-3236
(916) 920-6411

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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

MBC USE ONLY

1. Name — Last: Norrell — First: Laura — Middle: Lucille
2. Other names you have used (include maiden name):
3. Social Security Number (See disclosure statement on L1C)
4. Address — Number and Street/Rural Route (include apartment number, if any): 251 San Jose Avenue, Apartment 4
   City: San Francisco — State: CA — ZIP Code: 94110 — Country:
5. Telephone Number: Home — Work
6. Date of Birth: — Place of Birth:
7. Sex: [X] Female [ ] Male
8. Are you a U.S. citizen? [X] Yes [ ] No
   If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.
9. Have you ever filed an application for examination or licensure in California? [ ] Yes [X] No
   If YES, give date previous application was submitted.

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

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
DeKalb College	555 N. Indian C.D. Clarkston GA 30021	9/82	6/83
University of Georgia	Athens GA 30602-6113	9/83	5/87

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

Course	Yes	No	Name of College or University
Chemistry	✓		University of Georgia
Physics	✓		"
Biology or Zoology	✓		"

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

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Alabama School of Medicine	1670 University Blvd Birmingham AL 35294	Birmingham, AL	07/87	06/91

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

Name of Medical School	Address of Medical School	Exact Date of Issuance
University of Alabama School of Medicine	1670 University Blvd Birmingham AL 35294-0019	6/2/91

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

07A-100 (REV. 7/91)

MBC use only: PERSONAL DATA — NON-MEDICAL EDUCATION — MEDICAL EDUCATION — School Code:
L1A

MBC USE ONLY

WRITTEN EXAMINATION

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

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

☒ Yes ☐ No

Name	Location	Date	Result
National Boards Pt I	Birmingham AL	6/89	
Pt II	Birmingham AL	9/90	
Pt III	San Francisco CA	9/?/92	

POSTGRADUATE TRAINING

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?
(Note: [illegible] complete Form(s) [illegible] to document training received in research or clinical fellowship programs).

☒ Yes ☐ No

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

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of California San Francisco	505 Parnassus Avenue [illegible]	OB/GYN residency	6/91	currently

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

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes ____ No ____

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

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

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

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

If yes, give details below. Yes ____ No ____

State	Date	Charge	Disposition

L1B

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MBC USE ONLY

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

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

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

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

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

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

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

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

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

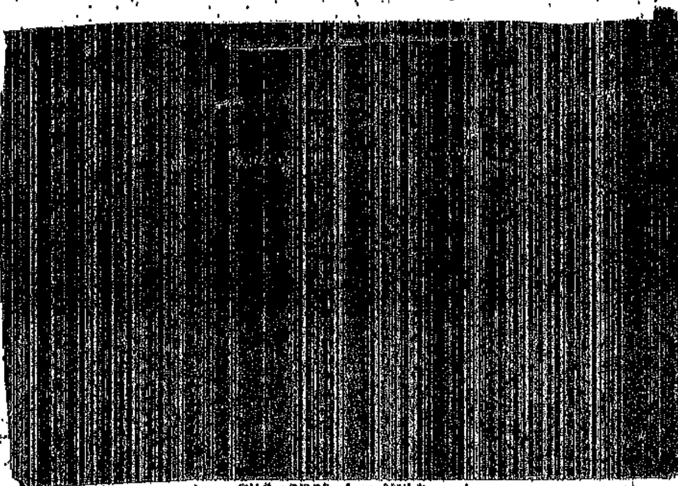
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

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

L1C



3½" x 5" Black and White

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

on or about ___

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. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

NOTARIZATION PORTION

STATE OF California

COUNTY OF San Francisco

Laura Lucille Norrell (PRINT FULL NAME OF APPLICANT) 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.

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

Laura Lucille Norrell
Signature of applicant (Write FULL name, not initials)

Signed and sworn to before me this 12th day of April, 1993

Signature of Notary Public [signature]

Address 3425 25th St. San Francisco CA. 94110

(NOTARY SEAL)

My commission expires 6-19-95

L1D

07A-103 (REV. 7/91)

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

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Laura Lucille Norrell (FULL NAME OF APPLICANT)

of [illegible] Circle [illegible] GA 3[illegible] (ADDRESS WHEN ENROLLED) enrolled in Univ. of Alabama School of Medicine (NAME OF MEDICAL SCHOOL)

Birmingham Alabama (LOCATION) on the 3[illegible] day of July (MONTH) 19 87 (YEAR)

and was granted the following credits on enrollment,

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

University of Georgia (EDUCATIONAL INSTITUTION) 9/83 – 5/87 (DATES)

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

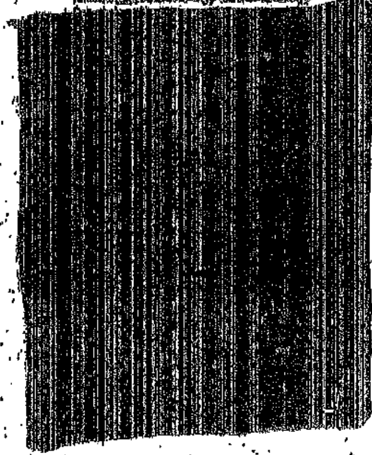
_______ (MEDICAL SCHOOL) _______ (TOTAL CREDITS) _______ (DATES)

The undersigned further certifies that the records of this institution show that she attended in this institution ____ (SHORT VERSION) years of resident instruction of ____ (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

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

the above-mentioned medical school on the 7th day of June (MONTH) 19 91.

[illegible]
[illegible]
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
Preventive Medicine, including Nutrition
Physical Medicine
Therapeutics
[illegible]
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia



Signed and the college seal affixed this 24th day of March, 19 93

BY Harold J. Fallon (PRESIDENT, SECRETARY, DEAN)

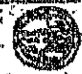
Harold J. Fallon, M.D., Dean

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 PETE WILSON, Governor



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

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

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

PART 1: To be completed by applicant/trainee.

Last Name of Trainee: Norrell First Name: Laura Middle Initial: L

Current Address: 251 San Jose Ave. Apt. [illegible] Phone Number:

City: San Francisco State: CA Zip Code: 94110

PART 2: To be completed by facility.

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

Name of Facility: University of California, San Francisco EK

Address of Facility: 505 Parnassus Avenue, BX 0132, San Francisco, CA 94143

Name of Program Director: James D. Goldberg, M.D. Phone Number: (415) 476-3192

Signature of Program Director: [signature] Date Signed: 4/19/93

Last Categorical Specialty Area of Training Completed by Trainee: OB/GYN Date Training Commenced: 6/21/91 Date Training Completed: 6/20/92

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

Straight training in OB/GYN - 12 months

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

(OVER)

L3A

07A-1-00-L3 (Rev. 2/92)

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

Name of Director of Medical Education:	James J. O'Donnell, M.D.	Phone Number:	(415) 476-4561
Facility Name:	University of California, San Francisco	Date Form Completed:	4/19/93
Facility Address:	505 Parnassus Avenue, BX 0132		
City:	San Francisco State: CA	Zip Code:	94143

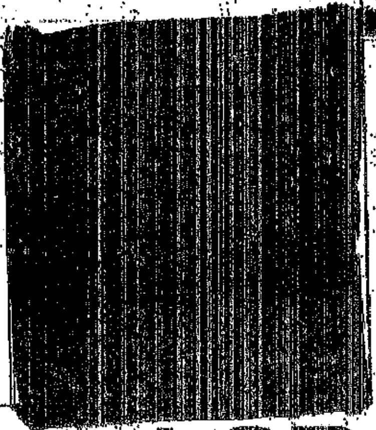
The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the recognized standards and the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

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

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

Signature of Director of Medical Education: James O'Donnell, M.D.

Date Signed: 4-19-93



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

L3B

07A-100-3 (Rev. 2/92)

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

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVE., STE. 54
SACRAMENTO, CA 95825-3236
(916) 920-6411

CERTIFICATION STATEMENT

This is to certify that [illegible] L. Norrell (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on June 21, 19 91 and is expected to be completed on June 30, 19 95 in Obstetrics and Gynecology (Type of Training), at University of California, San Francisco OK (Name and Address of Facility)

505 Parnassus Avenue, Box 0132, San Francisco, CA 94143

(AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY PUBLIC SEAL)

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.

James J. O'Donnell, M.D.
Type or print name of Director of Medical Education

James O'Donnell M.D. /es
Signature of Director of Medical Education

April 19, 1993
Date

(415) 476-4561
Phone Number

L9

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

07A-100-L9 (Rev. 3/91)

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Initial Renewal 1-105995/820.00 4/23/15 BS

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JUNE 30, 2015
NORRELL, LAURA L 3/17	**G76977**	**05/31/15**	**$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-Read **instructions above**

"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 3-25-15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060007697780105311500082000000089800

CHANGE OF MAILING ADDRESS **NORRELL, LAURA L** **G76977**

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

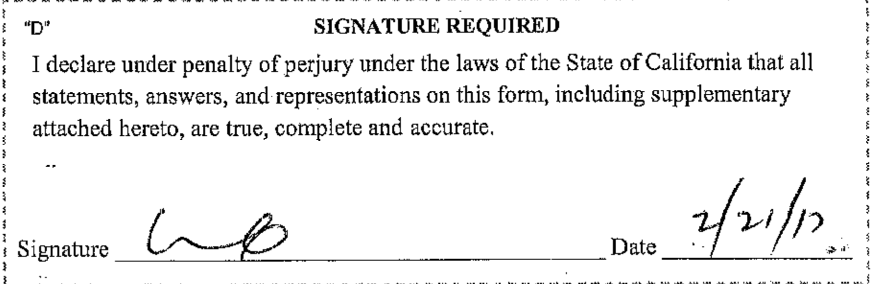
(DO NOT DETACH)

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JUNE 30, 2017
NORRELL, LAURA L	G76977	05/31/17	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" ☒ Completed Continuing Education (See Question 1)
- "E" ☐ Change of Address (fill in reverse side)
- "I" ☐ Conviction – Yes (See Question 3)
- "J" ☒ Conviction -- No (See Question 3)
- "F" ☐ Family Physician Training Program ($25 See Question 4)
- "G" ☐ Financial Interest Statement (See Question 5)


"D" **SIGNATURE REQUIRED**

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

Signature ____________ Date 2/21/17

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060007697780105311700082000000089800

CHANGE OF ADDRESS (Only if different from address above) **NORRELL, LAURA L** **G76977**

ADDRESS OF RECORD (Required)

Address Line 1

Address Line 2

02252017 20002757 20010030

Address Line 3

City State Zip -

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip -