KANSAS

STATE BOARD OF HEALING ARTS

235 S.W. Topeka Blvd.
Topeka, Kansas 66603-3068
(785) 296-7413
FAX (785) 296-0852

APPLICATION FOR LICENSURE

Medicine & Surgery X Osteopathic Medicine & Surgery____ Chiropractic____ Podiatry____

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. When space provided is insufficient, attach additional sheets of paper. You may reproduce these blank forms as needed, but each completed form must be submitted in original ink or type. MAKE SUFFICIENT COPIES OF ALL FORMS BEFORE YOU BEGIN.

****

APPLYING FOR LICENSURE BY: (Check appropriate item)

RECEIVED APR 10 2008

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____ NATIONAL BOARDS (N.B.M.E. or N.B.O.M.E. or N.B.C.E. or PMLexis)

____ FLEX ENDORSEMENT ____ STATE EXAM

____ USMLE ENDORSEMENT

____ COMBINATION OF FLEX, USMLE, NATIONAL BOARDS

____ LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (L.M.C.C.)

X USMLE STEP 3 EXAMINATION

____ PMLEXIS EXAMINATION ☐ December ☐ June

Please refer to Instruction Sheet for required proof of passage of Examinations.

****

I. GENERAL INFORMATION:

1. NAME Annie Marie Reising
   First Middle Maiden Last
2. Name as you wish it to appear on License: Annie Marie Reising
3. Address confidential
   Street City Venice, CA 90291
   State Zip
4. Phone (Res) confidential (Work) 310-825-9945 (FAX) N/A
5. Date of Birth confidential 75 6. SS NO: confidential
7. Place of Birth Kansas City, KS
8. Give location of intended practice in Kansas University of Kansas Medical Center
9. Primary Specialty Obstetrics and Gynecology American Board Certified No
   American Board Eligible Yes
10. A. E.C.F.M.G. Number if applicable N/A (notarized copy required)
    B. Fifth Pathway? ____ Yes X No If yes, provide notarized copy of certificate.
11. Have you ever been licensed to practice the Healing Arts in Kansas?
    ____ Yes X No

II. PROFESSIONAL ACTIVITIES—List in chronological order all activities since graduation, including absences from work, except for incidental sick leave and usual vacation. Also list all periods of nonprofessional activity or employment for more than three (3) months. Please account for all time and explain all gaps in activity. If engaged in private practice, list hospital affiliations. Use additional page(s) if necessary.

FROM Month/Year	TO Month/Year	LOCATION	ACTIVITY
06/04	06/08	UCLA - Department of OB/Gyn	OB/Gyn Residency

III. PROFESSIONAL SCHOOL Date Graduated 05 mo. 23 day 2004 year Degree M.D.

	Name of Institution	Address	Date from	Date to
1st yr	University of Kansas Medical Center	3901 Rainbow Blvd KC, KS 66160	09/00	05/23/2004
2nd yr	same			
3rd yr	same			
4th yr	same			
5th yr	N/A			
6th yr	N/A			

Have verification of Professional Education Form mailed direct to this office by medical school.

IV. POST-GRADUATE TRAINING (List chronologically) Send Enclosed Verification Form—Refer to Instruction Sheet

Name of Institution	Address	Type of Program	Dates From/To	Completed Yes/No
UCLA	10833 LeConte Ave OB/Gyn Department 27-139 CHS Los Angeles, CA 90095	OB/Gyn Residency	06/04 - 06/08	No

FELLOWSHIPS (List chronologically) Send Enclosed Verification Form—Refer to Instruction Sheet

Name of Institution	Address	Type of Program	Dates From/To	Completed Yes/No
N/A				

V. Have you ever been granted medical licensure by any state or territory?
(X) YES ( ) NO IF YES, LIST ALL CURRENT AND NON-CURRENT LICENSES BELOW:
Send Enclosed Verification Form—Refer to Instruction Sheet.

State or Territory	License Number	Effective Date	Current Status
Medical Board of California	A94130	02/17/2006	Active

VI. DISCIPLINE

WE ROUTINELY RECEIVE INFORMATION FROM VARIOUS STATES, FEDERAL AND PRIVATE AGENCIES AND ASSOCIATIONS ABOUT ACTIONS TAKEN AGAINST LICENSEES OR PRACTITIONERS. ALL INFORMATION RECEIVED WILL BE CHECKED ACCORDINGLY TO VERIFY THE TRUTH AND VERACITY OF YOUR ANSWERS. DOCUMENTATION MUST BE PROVIDED FOR ALL YES ANSWERS.

1. Have you ever been rejected for membership or notified by or requested to appear before any medical, osteopathic or chiropractic society?
   YES (NO) (Circle one)
2. Have you ever been denied the privilege of taking an examination administered by a licensing agency?
   YES (NO) (Circle one)
3. Have you ever been denied a license to practice the healing arts or other health care profession?
   YES (NO) (Circle one)
4. confidential
5.
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation, or other practice organization, either public or private?
   YES (NO) (Circle one)
7. Have you ever, for any reason, lost American Board certification?
   YES (NO) (Circle one)
8. Has any licensing or disciplinary agency limited, restricted, suspended or revoked a license you have held?
   YES (NO) (Circle one)
9. Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary agency?
   YES (NO) (Circle one)
10. Have you ever been notified or requested to appear before any licensing or disciplinary agency?
    YES (NO) (Circle one)
11. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
    YES (NO) (Circle one)
12. confidential
13.
14.
15.
16. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substances registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
    YES (NO) (Circle one)
17. Have you ever surrendered your state or federal controlled substances registration or had it restricted in any way?
    YES (NO) (Circle one)
18. confidential
19. Have you ever been a defendant in a legal action involving professional liability (Malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?
    YES (NO) (Circle one)
20. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?
    YES (NO) (Circle one)
21. Have you ever terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicare Program?
    YES (NO) (Circle one)

VII. STATEMENT OF HEALTH

confidential

VIII. ATTACH 3" X 4" PHOTOGRAPH IN BOX BELOW

dividual portrait must be taken within 90 days prior to date of pplication.

hotograph must be signed on back by applicant. (Head, houlders & upper chest—not full length)

ate photo taken written on back of photograph.

ttach photo with paper clips—do not paste.

IX. I, Annie Marie Reising, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A.) 21-3805)

Signature of Applicant

4/1/08
DATE

X. PROFESSIONAL LIABILITY INSURANCE (MALPRACTICE)

If you intend to render professional services in Kansas, you are required by K.S.A. 40-3401-3419 to obtain and maintain professional liability insurance of not less than $200,000 per occurrence (per claim) subject to not less than $600,000 annual aggregate for all claims made during the policy period and to participate in the Kansas Health Care Stabilization Fund. Proof of liability insurance must be provided at time of renewal.

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 Telephone (817) 868-4041

RECEIVED APR 17 2008

Date: 04/15/2008

Recipient:
Kansas Board of Healing Arts
ATTN: Licensing Department
235 SW Topeka Blvd
Topeka, KS 66603

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Examinee: Reising, Annie Marie
Alt Name(s):
Examinee ID#: 5-111-461-9
Date of Birth: 09/01/1975

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
06/11/2002	Pass	confidential				

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
07/24/2003	Pass	confidential				

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
CALIFORNIA 06/10/2005	Pass	confidential				

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Patent 5636874

KANSAS STATE BOARD OF HEALING ARTS

235 S. Topeka Blvd., Topeka, Kansas 66603-3068 (785)296-7413

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VERIFICATION OF PROFESSIONAL COLLEGE

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APR 11 2008
REGISTRAR'S OFFICE

University of Kansas Medical Center
Name of Institution

3901 Rainbow Blvd
Street

Kansas City KS 66160
City State Zip

I, Annie Marie Reising (M.D./D.O./D.C./D.P.M.) have applied for a license to practice in
(Print full name)

the state of Kansas. As part of the application process, the Kansas State Board of Healing Arts requires a verification of my Professional College.

I hereby authorize University of Kansas Medical Center its staff, or representative to provide the Kansas
(Name of professional college)

State Board of Healing Arts any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Kansas State Board of Healing Arts, 235 S Topeka Blvd., Topeka, Kansas 66603. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____
(Signature of applicant)

Date of Birth confidential 75

Social Security Number confidential

Date of Graduation 05 / 23 / 2004
MO DAY YR

For verification of PROFESSIONAL COLLEGE ONLY
Please provide exact dates

The following section must be completed by the dean or registrar of the professional school and returned directly to the Kansas State Board of Healing Arts. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that Annie Marie Reising
(Full name of applicant)

Enrolled in the School of Medicine at the University of Kansas
(Name of professional college)

on 08 / 07 / 00 (MO DAY YR) graduated 05 / 23 / 04 (MO DAY YR) with a degree in Doctor of Medicine

Further, the records of this institution indicate that the attached photograph
(check one) ☒ Represents a true likeness of the above-named applicant.
☐ Does not represent a true likeness of the above named applicant.

By Dorothy Knoll
Signature of the dean or registrar Dorothy Knoll, Dean of Students

SEAL

Attach Passport size Photograph here

Signed and the college Seal affixed on 04 / 16 / 08
MO DAY YR

Professional college seal MUST be imprinted partially on photograph.

The University of Kansas

By the authority of the Board of Regents of the State of Kansas and upon the recommendation of the Faculty of the

School of Medicine

confers upon

Annie Marie Reising

the degree of

Doctor of Medicine

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas
this twenty-third day of May, two thousand and four.

State Board of Regents

Chair

Chancellor

Executive Vice Chancellor

Executive Dean, School of Medicine

Dean

I certify this to be a true and accurate copy of the original diploma awarded to Annie Marie Reising for the Doctor of Medicine degree by the University of Kansas School of Medicine May 23, 2004.

Chris Meier
Assistant Dean of Students/Registrar
April 11, 2008

KANSAS STATE BOARD OF HEALING ARTS

235 S. Topeka Blvd., Topeka, Kansas 66603 (785)296-7413

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VERIFICATION OF POSTGRADUATE TRAINING

Gautam Chaudhuri, MD
Name of Program Director

University of California – Los Angeles (UCLA)
Name of Institution

10833 Le Conte Ave, OB/Gyn Dep't 27-139 CHS
Street

Los Angeles CA 90095
City State Zip

I, Annie Marie Reising, have applied for a license to practice in the state of Kansas.
(Print full name)

As part of the application process, the Kansas State Board of Healing Arts requires a reference from the program director of each ACGME accredited Postgraduate Training program to which I have been appointed.

I hereby authorize University of California – Los Angeles (Name of Institution), its staff, or representative to provide the Kansas State Board of Healing Arts any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Kansas State Board of Healing Arts, 235 S Topeka Blvd., Topeka, Kansas 66603. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, (applicant)

Date of Birth confidential 75

Social Security Number confidential

For verification of POSTGRADUATE TRAINING
Please provide exact dates

The following section must be completed by the Program Director or his/her representative and returned directly to the Kansas State Board of Healing Arts. Verifications returned to applicant will not be accepted.

This is to certify that Annie Marie Reising (Name of applicant), a graduate of University of Kansas Medical Center (Professional School)

commenced postgraduate training (internship/residency/clinical fellowship*) in OB/Gyn at UCLA – 10833 Le Conte Ave, LA, CA 90095 (Name and address of training program)

on 06 / 24 / 2004 (MO DAY YR) and completed (check one) ☑ successfully ☐ unsuccessfully such training on 06 / 23 / 2008 (MO DAY YR)

☑ Internship - Name of Dept. Obstetrics & Gynecology

☑ Residency - Name of Dept. Obstetrics & Gynecology

☑ Fellowship - Name of Dept. N/A ☐ Clinical ☐ Research

Signed G Chaudhuri

Date Signed 04/01/2008

Title Program Director & Chairman

Tel. No. (310) 825-9945

SEAL

COMMENTS: _____
(Attach additional sheet if needed)

*Circle one

STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944

www.mbc.ca.gov

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APR 24 2008

April 21, 2008

KANSAS BOARD OF HEALING ARTS
235 SOUTH TOPEKA BLVD
TOPEKA KS 66603-3068

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	ANNIE MARIE REISING
License No.:	A 94130
Issued:	February 17, 2006
Exam Type:	A written examination
Expiration Date:	September 30, 2009
Status:	Renewed/current
Board Discipline:	NO

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Kimberly Kirchmeyer
Deputy Director

SEAL