

Application Summary

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License Type: **Physician's and Surgeon's**
Application: **Physician's and Surgeon's - Initial Application**
Application Number: **14438509**
Application Date: **07/10/2017 (mm/dd/yyyy)**

Application Questions

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

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

Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the Armed Forces?

Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?

Personal Detail

Title: **Dr.**
First Name: **MELISSA**
Middle Name: **BROOKS**
Last Name: **NOTHNAGLE**
Birthdate: ******/******
Gender: **Female**
SSN/ITIN: *********

Addresses

License Related Addresses

Address of Record (Required)

Warning:

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

Education History

Medical School Name: **University of California-San Francisco School of Medicine**
Attendance Start Date: **09/04/1995 (mm/dd/yyyy)**

Attendance End Date 06/13/1999 (mm/dd/yyyy)
 Graduation Date 06/13/1999 (mm/dd/yyyy)
 Title of Degree Awarded MD - Doctor of Medicine
 Mailing Address of the Medical School 513 Parnassus Ave. San Francisco, CA 94143
 -0410

Personal Information

Country of Birth: United States

US State of Birth:

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 Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?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

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?

Examinations 1

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

Exam Date: 06/1997 (mm/yyyy)

Exam Result:

Examinations 2

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

Exam Date: 03/1999 (mm/yyyy)

Exam Result:

Examinations 3

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

Exam Date: 10/2000 (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: **Rhode Island**

Program/Facility Name **Memorial Hospital of Rhode Island**

Specialty: **Family Medicine**

Training Start Date: **06/24/1999 (mm/dd/yyyy)**

Training End Date: **06/30/2002 (mm/dd/yyyy)**

Program Location Address: **111 Brewster St
Pawtucket, RI 02860**

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 **Rhode Island**
License Number: **10942**
Issue Date: **07/12/2002 (mm/dd/yyyy)**
Expiration Date: **06/30/2018 (mm/dd/yyyy)**

Medical License Information 2

State/Province **Massachusetts**
License Number: **213320**
Issue Date: **02/13/2002 (mm/dd/yyyy)**
Expiration Date: **01/15/2019 (mm/dd/yyyy)**

ABMS Certification

34. Are you currently certified by a Member Board of the American board of Medical Specialties? **Yes**

Member Board: **American Board of Family Medicine**
Certification Number: **112965**
Expiration Date: **12/31/2019 (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:

Rhode Island

Expiration Date:

10/31/2017 (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

Timeline of Activities.docx	Timeline of activities
Nothnagle_Melissa_CV_5_17.doc	curriculum vitae

Fees

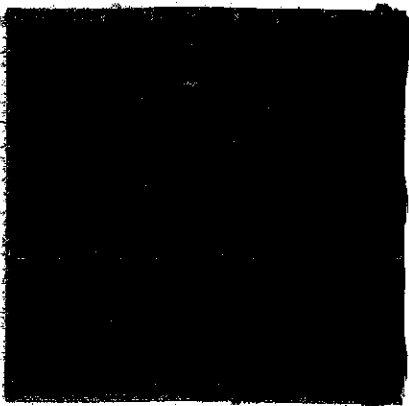
Application Fee	\$442.00
Department of Justice (DOJ) Fee	\$32.00
Federal Bureau of Investigation (FBI) Fee	\$17.00
Initial License Fee	\$783.00
StephenM.ThompsonLRP	\$25.00
Total Amount Due:	\$1299.00

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

Attestation

7/10
2029767

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

Applicant Name & Date

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DECLARATION

The applicant, Melissa Brooks Nothnagle
PRINT LEGAL NAME (First, Middle, Last, Suffix) 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

SIGN LEGAL NAME: [Signature] DATE: 7/7/17

NOTARY SECTION

SIGNATURE OF APPLICANT: [Signature]
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Rhode Island

County of Providence

Subscribed and sworn to (or affirmed) before me on this 7 day of July, 2017.

by, Melissa Brooks Nothnagle proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

[Signature]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL
Douglas P. Frongillo
Notary Public, Rhode Island
My Commission Expires February 10, 2019
Notary I.D. 44636

LIF