



MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov



2008 JUN -2 PM 4:07

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): [X] License [ ] PTAL - or - [ ] Update

1. NAME: Last MEMMEL, First LISA, Middle MARIE
Other names you have used (include maiden name):
2. U.S. Social Security Number
3. Place of Birth
4. Date of Birth
5. Gender: [ ] Male [X] Female
6. Public/Mailing Address: 535 N MICHIGAN AVE #2511
City CHICAGO, State/Province IL, Zip/Postal Code 60611, Country USA
7. Telephone Numbers: Home, Work, Cell
8. California Driver's License Number (optional)
9. E-mail Address (optional)
10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? [ ] Yes [X] No
Previous license number, if any:

MBC Use Only
Personal Data

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.
Table with columns: School Name, City, State/Province, Country, Dates of Attendance
12. School of Graduation, Degree Awarded, Date of Graduation

Transcript
Diploma

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada
Table with columns: Examination, Date, Result (Pass/Fail)

Exams

Web 5-20-08 503.00 WI 006
Cashing Line Only School Code

L1A



### ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties?  
 YES  NO

Member Board	Expiration Date	Certificate Number

### MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$30,000 or more?  
 YES  NO

### PRACTICE IMPAIRMENT OR LIMITATIONS

- |  |                              |  |
|--|------------------------------|--|
| 18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 19. Have you been treated for or had a recurrence of a diagnosed addictive disorder?   | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely?          | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?     | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?                                 | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

### CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

**This includes a citation, infraction, misdemeanor and/or felony, etc.** If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.

YES  NO

**APPLICANT:**

MEMMEL, LISA MARIE

**DATE OF BIRTH:**

[REDACTED]

L1C

ABMS Uses Only  
 ABMS  
 Malpractice  
 Limitations  
 Criminal Record



Notice: All items in this application, except #8 and #9, 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 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 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.

The applicant, LISA MARIE MEMMEL (PLEASE PRINT FULL NAME) [REDACTED] (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 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 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.

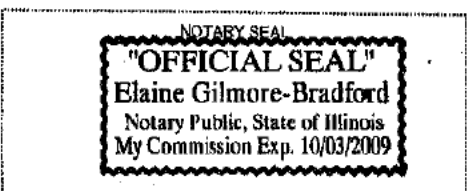
LM (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: [Signature] (Please sign full name)

State of Illinois  
County of Cook

Subscribed and sworn to (or affirmed) before me on this 20<sup>th</sup> day of May, 2008, by Lisa Memmel, M.D.

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.



[Signature]  
SIGNATURE OF NOTARY PUBLIC

**L1E**



RECEIVED MEDICAL BOARD OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 (800) 633-2322 (916) 263-2392 FAX (916) 263-2487 www.mbc.ca.gov

RECEIVED MAY 27 2008



2008 JUN 24 PM 1:38

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that LISA MARIE MERMEL Full Name of Applicant; [redacted] U.S. Social Security Number [redacted] Date of Birth [redacted] enrolled in MEDICAL COLLEGE OF WISCONSIN Name of Medical School located in Milwaukee, Wisconsin, U.S.A. State/Province Country on 08 / 12 / 1997 Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2) and that the applicant

Anatomy Otolaryngology Obstetrics and Gynecology Radiology, including Radiation Safety Tropical Medicine Physiology Biochemistry Pathology, Bacteriology, and Immunology Ophthalmology Dermatology

Embryology Histology Human Sexuality Medicine Surgery, including Orthopedic Surgery Urology Psychiatry Neurology Alcoholism and Chemical Dependency Preventative Medicine, including Nutrition

Physical Medicine Therapeutics Neuroanatomy Child Abuse Detection and Treatment Geriatric Medicine Pediatrics Pharmacology Anesthesia Spousal Partner Abuse Detection & Treatment\* Family Medicine\*\* Pain Management and End-of-Life-Care\*\*\*

\* 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.

[X] was granted the degree of Bachelor/Doctor of Medicine on the 19th day of May, 2001 [ ] withdrew from medical school on \_\_\_ day of \_\_\_

Unusual Circumstances

Responses

Did this individual ever take a leave of absence from their medical education? Yes [redacted] No [redacted] Was this individual ever placed on probation? Yes [redacted] No [redacted] Was this individual ever disciplined or under investigation? Yes [redacted] No [redacted] Were any incident reports regarding this individual ever filed by instructors? Yes [redacted] No [redacted] Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? Yes [redacted] No [redacted]

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature 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 18th day of June, 2008. By: Lesley A. Mack, Registrar Printed Name and Title of School Official Signature: [Handwritten Signature]

L2

# The Medical College of Wisconsin

has conferred on

**Lisa Marie Memmel**

the degree of

**Doctor of Medicine**

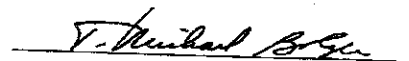
with all the rights and privileges thereunto appertaining.

In Witness Whereof, this diploma is granted by the  
Board of Trustees upon recommendation of the Faculty.

Presented at Milwaukee, Wisconsin, this 19th day of May, 2001.

  
Chairman, Board of Trustees

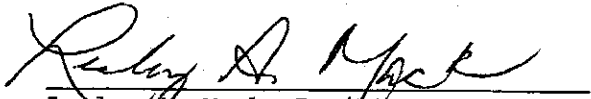


  
President and CEO

  
Dean and Executive Vice President

June 18, 2008

This is to certify that the reverse hereof is a true and exact copy of the diploma issued to Lisa Marie Memmel, M.D., by the Medical College of Wisconsin.

A handwritten signature in cursive script, appearing to read "Lesley A. Mack", written over a horizontal line.

Lesley A. Mack, Registrar  
The Medical College of Wisconsin  
Notary Public/State of Wisconsin

My commission expires April 11, 2010.



6/2



**Illinois Department of Financial and Professional Regulation**  
**Division of Professional Regulation**

ROD R. BLAGOJEVICH  
Governor

RECEIVED  
MEDICAL BOARD OF  
CALIFORNIA

2008 JUL -2 AM 10:38  
DEAN MARTINEZ  
Secretary

DANIEL E. BLUTHARDT  
Director  
Division of Professional Regulation  
**LICENSING PROGRAM**

**CERTIFICATION OF LICENSURE**

June 23, 2008

MEDICAL BOARD OF CALIFORNIA  
2005 EVERGREEN ST SUITE 1200  
SACRAMENTO, CA 95815

Licensee: LISA M MEMMEL MD

License Number: 036.116173

Profession: LICENSED PHYSICIAN AND SURGEON

Date of Issuance: 06/08/2006


Expiration Date: 07/31/2011

License Status: ACTIVE

License Method: ACCEPT EXAM - USMLE

Disciplinary History: Has not been disciplined

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

  
Daniel E. Bluthardt  
Director  
Division of Professional Regulation



Refer to the Department's Web Site at [www.idfpr.com](http://www.idfpr.com) to verify professional licenses via License Lock-Up.

Please contact the Division of Professional Regulation, Licensure Maintenance Unit, at 217-782-0458 if you have any questions.



**MEDICAL BOARD OF CALIFORNIA**  
 LICENSING PROGRAM  
 2005 Evergreen Street, Suite 1200  
 Sacramento, CA 95815  
 (800) 633-2322 (916) 263-2382 FAX (916) 263-2487  
 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA



2008 JUL -1 AM 9:39

LICENSING PROGRAM

**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.

**PART 1: TO BE COMPLETED BY THE APPLICANT**

NAME: Last <b>MEMMEL</b>		First <b>LISA</b>	Middle <b>MARIE</b>
U.S. Social Security Number [REDACTED]	Date of Birth [REDACTED]	Telephone Number Home [REDACTED] Work ( )	
Public/Mailing Address <b>535 N MICHIGAN AVE # 2511</b>			
City <b>CHICAGO</b>	State/Province <b>IL</b>	Zip/Postal Code <b>60611</b>	
Medical School of Graduation: <b>MEDICAL COLLEGE OF WISCONSIN</b>			

**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 satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility: <b>University of Washington - OBYN</b>	ACGME 10 digit Program number: (www.acgme.org) <b>2205421301</b>	
Address of Facility: <b>195A NE Pacific Street Box 356340</b>	Telephone #:	
Categorical Specialty Area of Training <b>OBYN</b>	Start Date of Training <b>06/25/2002</b>	End Date (or anticipated completion date) of Training <b>06/30/2006</b>

**UNUSUAL CIRCUMSTANCES:**

Did the trainee ever take a leave of absence or break from their training?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever terminated, dismissed or expelled?	YES	[REDACTED]	NO	[REDACTED]
Did the trainee ever resign?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever placed on probation?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever disciplined or placed under investigation?	YES	[REDACTED]	NO	[REDACTED]
Were any incident reports regarding this trainee ever filed by instructors?	YES	[REDACTED]	NO	[REDACTED]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	[REDACTED]	NO	[REDACTED]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	[REDACTED]	NO	[REDACTED]

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

**L3A**

### DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.

### GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1

has completed     has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSA.

*[Handwritten Signature]*  
SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING
	The training program is accredited by the ACGME or the RCPSA to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSA program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.
	<i>Seine Chiang, MD</i> PRINT NAME OF PROGRAM DIRECTOR
	<i>[Handwritten Signature]</i> SIGNATURE OF PROGRAM DIRECTOR Signature Stamp is Not Acceptable
	<i>6/25/08</i> DATE SIGNED

State of Washington

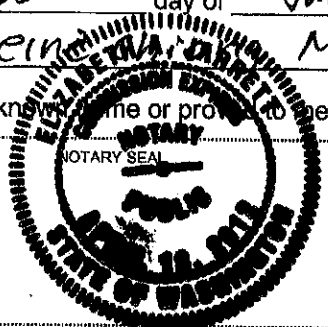
County of King

Subscribed and sworn to (or affirmed) before me on

this 25 day of June, 2008

by Seine Chiang MD

personally known to me or produced to me on the basis of satisfactory evidence to be the person(s) who appeared before me.



*Elizabeth A. Jarron*  
SIGNATURE OF NOTARY PUBLIC

**L3B**

## Application Summary

9/12/14 2:00 PM

Page 1 of 3

License Type: **Physician and Surgeon A**  
License Number: **105720**  
File Number: **91833**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14103484**  
Application Date: **09/12/2014 (mm/dd/yyyy)**

### Personal Detail

First Name: **LISA**  
Middle Name: **MARIE**  
Last Name: **MEMMEL**  
Birthdate: **\*\*\*f\*\*\***  
Gender: 

### Addresses

#### License Related Addresses

##### Confidential Address (Optional)

Warning:

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

##### License Specific Public/Mailing Address (Required)

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?



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?



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.



**Family Physician Training Program Voluntary Fee**

Voluntary Fee:



**Attachments**

**Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - 10-19 Hours

Other - None

Patient Care - 20-29 Hours

Research - 1-9 Hours

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 94901 County: MARIN

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

Obstetrics and Gynecology - Primary

Board Certifications

American Board of Obstetrics and Gynecology - Obstetrics and Gynecology

Postgraduate Training Years

6 Years

Cultural Background



Foreign Language Proficiency

Cultural Background - No

Web Site Profile

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:




## Application Summary

9/22/16 9:28 AM


Page 1 of 3

License Type: **Physician and Surgeon A**  
License Number: **105720**  
File Number: **91833**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14312745**  
Application Date: **09/22/2016 (mm/dd/yyyy)**

### Application Questions

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

### Personal Detail

First Name: **LISA**  
Middle Name: **MARIE**  
Last Name: **MEMMEL**  
Birthdate: **\*\*\*\*/\*\*\*\*/\*\*\*\***  
Gender: 

### 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? 

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? 

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.

**Family Physician Training Program Voluntary Fee**

Voluntary Fee:

**Attachments**

**Physician Survey**

Are you retired? - **No**

Activities in Medicine

**Administration - 1-9 Hours**

**Other - None**

**Patient Care - 30-39 Hours**

**Research - 1-9 Hours**

**Teaching - 1-9 Hours**

**Telemedicine - None**

Patient Care Practice Location **Zip: 94911 County: MARIN**

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 **Obstetrics and Gynecology - Primary**

Board Certifications **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**

Postgraduate Training Years **2 Years**

Web Site Profile **Cultural Background - No**

**Foreign Language Proficiency - No**

**Gender - No**

E-mail:

**Fees**

Biennial Renewal Fee	<b>\$783.00</b>
DUE TO CURES FUND	<b>\$12.00</b>
Steven M. Thompson Physician Corps Loan Repayment Program	<b>\$25.00</b>



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: