Person Info
Name:LISA KIM PERRIERA
Address Info
Street Address: [redacted] **Email** [redacted]@hotmail.com
Phone [redacted]
Fax
CityCleveland Heights
StateOH
Zipcode44118
Country82
CountyCuyahoga

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	PA, OH
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as	N

to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
If you answer "No", please provide an explanation or reason for an exemption request.	I have not practiced in PA in the last 2 years.

Date Submitted:	Tuesday, October 14, 2014

Education Info

No education records

Employment Information

No employment records

Person Info
Name:LISA KIM PERRIERA
Address Info

Street Address [redacted] **Email** [redacted]@hotmail.com

Phone [redacted]
Fax
CityCleveland Heights
StateOH
Zipcode44118
Country82
CountyCuyahoga

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks
Remarks:
Continuing Education Information

No CE Course records

Person Info
Name: LISA KIM PERRIERA
Address Info
Street Address [redacted] **Email:** [redacted]@hotmail.com
Phone [redacted]
Fax
City Wynnewood
State PA
Zipcode 19096
Country 82
County Montgomery

Survey Response Summary	
Question Response Summary	
Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction.	Physician license in Ohio
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	19107

Date Submitted: Thursday, October 20, 2016

Education Info

No education records

Employment Information

No employment records

TARGET SHEET

Board: Medicine

Date Created:
02/15/2007

Licensee Full Name:
LISA KIM FERRIERA

Licensee No:
MD430904

APPL 2467371

[illegible]

MD 9 0 7 8 4

Regular Mailing Address:
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Courier Delivery Address:
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

Phone: 717-783-1400 or 717-782-2181
[illegible]@state.pa.us

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION

For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

[illegible]

Application Fee $35.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania"
Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Please Print or Type

NAME: Perrera (Last) Lisa (First) Kim (Middle)

Permanent Address: [redacted] (Street)

All correspondence and licenses will be mailed to the address above. (Board is unable to accept [illegible])

New York (City) NY (State) 10003 (Zip code)

Email address: [redacted]@hotmail.com

Date of Birth: [redacted] Social Security Number: [redacted]

If your medical/licensure records are listed under another name or names list below

Are you applying using credentials verification from FCVS? YES ✓ NO

Have you previously held a Pennsylvania graduate training license?
YES, My license number is ____ ✓ NO

FIRST MEDICAL SCHOOL (S) ATTENDED	DATES OF ATTENDANCE
State University of New York at Stony Brook	From 8/1993 (M.D. & Y.) to 6/2000 (M.D. & Y.)
	From ____ (M.D. & Y.) to ____ (M.D. & Y.)

Date of Graduation 6/24/07

Check licensing examination(s) passed:

( ) FLEX - indicate state where taken — Date taken — Component 1 — Component 2
( ) NATIONAL BOARD - PART I — PART II — PART III
(✓) USMLE - STEP 1 ✓ STEP 2 ✓ STEP 3 ✓
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken

ACGME Post Graduate Training:

PGY1 Hospital New York University Hospital from [illegible] to [illegible]

PGY2 Hospital New York University Hospitals from [illegible] to [illegible]

Answer the following questions. If "YES" is answered to #2 through #8, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
[illegible] If yes, list the jurisdiction (s) below.		✓
[illegible]		✓
[illegible] If yes, list the jurisdiction (s) below.		✓
[illegible]		✓
[illegible]		✓
[illegible]		✓
[illegible] (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)		✓
[illegible] Complaint [illegible] docket number, filing date, [illegible] entire Civil [illegible] date you were served		✓

SIGNED STATEMENT

[illegible]

[illegible]

[illegible]

[redacted]

Signature of Applicant

1/3/07
Date

State Board of Medicine
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Certification of Moral Character

To be completed by **two** physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at **least six months**.

Name of Applicant [illegible]

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 3 year(s) 6 month(s)

SIGNATURE [redacted] Date 1/3/07

Print or type name as signed above

State in which licensed License Number

JOANNE MAYER HOPE, MD
NY License # 240486
DEA # BH0093311
OB/GYN MDID # 765335

Name of Applicant [illegible]

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 2 year(s) 6 month(s)

SIGNATURE [redacted] Date 1/3/07 DS

Print or type name as signed above DAVID E. SCHOENFELD MD

State in which licensed NY License Number 185196

Return Completed Form to Applicant

49-185 (BEA 6/96)

1/15/50

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

RECEIVED DIRECT

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
Accredited Medical School Graduates

NAME: Pereira (Last) Lisa (First) Kim (Middle)

1. If training began before July 1, 1987, one year of approved training at a first (PGY-1) or second (PGY-2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY-1) year level and one at second (PGY-2) year level.
2. Training at a first (PGY-1) year must be ACGME approved entry level training which requires no previous training. Training at a second (PGY-2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: New York University

NAME OF SPONSORING INSTITUTION: New York University School of Medicine

LOCATED IN: New York (City) New York (State)

1st Year from 07 01 1993 To 06 30 2004 Specialty Obstetrics & Gynecology Level (PGY) 1

2nd Year from 07 01 2003 To 06 30 2004 Specialty Obstetrics & Gynecology Level (PGY) 2-4

→ **"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."**

Signature of Program Director

[Seal of Hospital] Date 11/1/01

If the hospital has no seal, complete the following section and have this form notarized:

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature

Date

Notary's Commission expires on:

[Notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

State Board of Medicine
717-783-1400
717-787-2381

RECEIVED DIRECT

VERIFICATION OF MEDICAL EDUCATION

For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: Perriera (Last) Lisa (First) Kim (Middle)

Name of medical school: State University of New York at Stony Brook

Location: Stony Brook, NY

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THIS COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: [illegible]

Date student began to attend this medical school: [illegible]

Date of graduation: [illegible]

(Seal of School)

I certify that all of the above information is correct

Signature of Dean or Registrar: [illegible]

Date: [illegible]

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

111580

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 Plaza, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 01/03/2007

Recipient:

Pennsylvania State Board of Medicine
ATTN: Cindy L. Warner, Administrator
PO Box 2649
Harrisburg, PA 17105-2649

RECEIVED FMC

Examinee: Pereira, Lido
Alt Name(s): Pereira, Lido Kun

Examiner ID#: 5-084-118-3
Date of Birth: [redacted]

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
	06/22/2001	Pass	235	182	91	75	

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
	01/30/2003	Pass	228	171	90	75	

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	09/08/2005	Pass	221	184	92	75	

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

Lisa K. Perriera

[redacted]
New York, NY 10003
[redacted]
[redacted]@hotmail.com

Medical training

2003-present New York University School of Medicine, Department of Obstetrics and Gynecology, Resident

Education

2003 MD State University of New York at Stony Brook, School of Medicine, Stony Brook, New York

1997 BA Colgate University, Hamilton, NY
Major: Biology
Cum Laude graduate

Licensure

2006 State of Pennsylvania License, in process

Academic Achievement

2003 Alpha Omega Alpha, Honor Medical Society

1996-1997 Dean's List, Colgate University

1996 Beta Beta Beta
-National Honor Society for Biology Concentrators

1993 Colgate Alumni Memorial Scholar
-full tuition scholarship given to exceptional applicants at time of acceptance

1993 Phi Eta Sigma
-National Academic Honor Society for First Year College Students

Current Research Interest

2005-present A Randomized Controlled Trial of Laminaria and Buccal Misoprostol Before Late First Trimester Abortion
Advisor: Rachel Masch, MD, Associate Director of Family Planning Division, Department of Obstetrics and Gynecology, New York University School of Medicine

Employment Experience

1997-1999 Medical Assistant, Martin Gubernick, MD, OB/Gyn
-Assisted with routine exams and in-office surgical procedures.

1996 Research Assistant, Steven Albert, PhD, Columbia University
-Interviewed subjects for grant funded studies on quality of life in patients with Prostate Cancer and Alzheimer's Disease.

Professional Affiliations

2006 Bellevue Obstetrical and Gynecological Society
2005-present Physicians for Reproductive Choice and Health
2003-present American College of Obstetrics and Gynecology, Junior Fellow
1999-2003 Medical Students for Choice

Professional Development

2006 American College of Obstetrics and Gynecology Annual Meeting
1998 Medical Students for Choice Leadership Conference

Volunteer Experience

2005 Host Committee Member, Third Wave Foundation Holiday Fundraiser
2003 Guest Lecturer, Flushing YMCA Women's Group
-discussed the effects of menopause to a mature women's group
1999-2001 AIDS Community Teaching
1999-2001 Stony Brook Chapter Leader, Medical Students for Choice

Teaching Experience

2003-present Clinical Instructor, New York University School of Medicine, Department of Obstetrics and Gynecology
1994-1995 Student Tutor, General Chemistry, Colgate University

Languages

Proficient in Spanish

Interests

Scuba diving, traveling, marathon running, fine dining, attending concerts and the theater