Amended 2/17/12 CH

RECEIVED

JAN 10 2012

Application #: 0352359
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

WASHINGTON SIERRA LEN
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☒ Other degree MSC ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: Month Day Year Social Security Number:

Place of Birth: City State/Province/Territory Country if not USA

*Mailing Address: C/O SARAH ROBERTO 888 COMMONWEALTH AVE 3RD FLR Telephone: 617-9980181
Number and Street

BOSTON MA 02215
City State/Province/Territory Zip (or postal) Code

Home Address: Telephone:
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: C/O SARAH ROBERTO 888 COMMONWEALTH AVE 3RD FLR Telephone: 6179980181
Number and Street

BOSTON MA 02215
City State/Province/Territory Zip (or postal) Code

E-mail Address: Fax number:

Are you applying for licensure through FCVS? (See instructions page 12) ☒ Yes ☐ No

* The Board will use your Mailing Address for all correspondence

Amended 2/17/12 CH

PRINT NAME: WASHINGTON

Pre-medical School

			From	To
Facility: STANFORD UNIVERSITY	Degree: BA		8/-/94	6/14/98
Street:	City:		State:	
Facility:	Degree:		/ /	/ /
Street:	City:		State:	

Medical School

			From	To
Facility: HARVARD MEDICAL SCH.	Degree: MD		9/2/99	6/9/05
Street:	City:		State:	
Facility:	Degree:		/ /	/ /
Street:	City:		State:	

Date of medical school graduation: 06 / 9 / 2005
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

			From	To
Facility: LONDON SCHOOL OF HYGIENE	Position: GRADUATE STUDENT		1/9/02	1/8/03
Street: KEPPLER ST.	City: LONDON		State: UK	
Facility: UNIVERSITY OF CALIFORNIA	Position: PGY1-4		6/21/05	6/20/09
Street: 505 PARNASSUS	City: SAN FRANCISCO		State: CA	
Facility:	Position:		/ /	/ /
Street:	City:		State:	
Facility:	Position:		/ /	/ /
Street:	City:		State:	
Facility:	Position:		/ /	/ /
Street:	City:		State:	

Amended 2/12

PRINT NAME: WASHINGTON

Pre-medical School

			From	To
Facility: STANFORD UNIVERSITY	Degree: BA		9/-/94	6/14/96
Street:	City:	State:		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: HARVARD MEDICAL SCH.	Degree: MD		9/2/99	6/9/05
Street:	City:	State:		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 06 / 9 / 2005
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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			From	To
Facility: LONDON SCHOOL OF HYGIENE	Position: GRADUATE STUDENT		9/02	/3/03
Street: KEPPLER ST	City: LONDON	State: UK		
Facility: UNIVERSITY OF CALIFORNIA	Position: PGY1-4		6/24/05	6/30/09
Street: 505 PARNASSUS	City: SAN FRANCISCO	State: CA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

PRINT NAME: WASHINGTON

Pre-medical School

Facility: STANFORD UNIVERSITY Degree: BA From 8/-/94 To 6/4/98
Street: City: State:

Facility: Degree: From / / To / /
Street: City: State:

Medical School

Facility: HARVARD MEDICAL SCH. Degree: MD From 6/-/99 To 6/9/05
Street: City: State:

Facility: Degree: From / / To / /
Street: City: State:

Date of medical school graduation: 06 / 9 / 2005
Month Day Year

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From To

Facility: LONDON SCHOOL OF HYGIENE Position: GRADUATE STUDENT 1/9/02 / 8/03
Street: KEPPLER ST. City: LONDON ~~State:~~ UK

Facility: UNIVERSITY OF CALIFORNIA Position: PGY1-4 6/21/05 6/20/09
Street: 500 PARNASSUS City: SAN FRANCISCO State: CA

Facility: Position: / / / /
Street: City: State:

Facility: Position: / / / /
Street: City: State:

Facility: Position: / / / /
Street: City: State:

Amended 2/17/12 CH

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I	6/01	☑ P	☐ F	1
USMLE Step II	9/02	☑ P	☐ F	1
USMLE Step III	6/06	☑ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part 1		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	4/20/07 CALIFORNIA (State of examination)	☑ P	☐ F	1

Attended 2/12

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USMLE Step I	6/01	☑ P	☐ F	1
USMLE Step II	9/02	☑ P	☐ F	1
USMLE Step III	6/06	☑ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	4/20/07 CALIFORNIA (State of examination)	☑ P	☐ F	1

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Examination	Most Recent Date taken (Month/Year)	Passed (P)	or Failed (F)	Number of attempts
USMLE Step I	01/19/01	☑ P	☐ F	1
USMLE Step II	CK: 6/14/02 CS: 9/15/04	☑ P	☐ F	1
USMLE Step III	4/13/06	☑ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part 1		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	4/20/07 CALIFORNIA (State of examination)	☑ P	☐ F	1

PRINT NAME: WASHINGTON

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
INDIANA UNIVERSITY DEPT OF OBGYN Facility: WISHARD HOSPITAL Street: 1001 W 10TH ST	Position: STAFF MD City: INDIANAPOLIS	1/8/09 State: IN	1/10/11
Facility: MOI TEACHING & REFERRAL Street: NANDI ROAD	Position: CONSULTANT MD City: ELDORET State: KENYA	1/8/09	1/10/11
Facility: SAN FRANCISCO COUNTY Street: 1001 PROTRERO AVE	Position: RESIDENT City: SAN FRANCISCO State: CA	1/6/05	1/6/09
Facility: UCSF HOSPITAL Street: 505 PARNASSUS	Position: RESIDENT City: SAN FRANCISCO State: CA	1/6/05	1/6/09

1. List other states (abbreviations) where you are currently or have ever had a full license: CA IN HI
2. a) Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☐ No
3. List Board Certification(s): AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY — Certification date: ___/___/___ — Certification date: 12/9/11
4. List your practice specialt(ies) OBGYN
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: NEW JOB AT HARVARD MEDICAL SCHOOL & PARTNERS IN HEALTH; DIMMOCK HEALTH CENTER
7. Name of Facility: DIMMOCK HEALTH CENTER; BETH ISREAL
   Address: LONGWOOD City: BOSTON
8. Anticipated starting date in Massachusetts: 1/1/12

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature of Applicant

12 / 20 / 11
Month Day Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: 1 3 8 6 8 4 5 1 6 2

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 12/20/11

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/med university of graduation for verification.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your

Applicant's Signature: [signature] Date of Birth

Print or Type Name: WASHINGTON (Last name) SIERRA (First Name) LI'EN (Middle Initial) Social Security N

Other Name(s) (Please type or print name(s))

Name of Medical School: HARVARD MEDICAL SCHOOL

Address: 25 SHATTUCK ST. GORDON HALL ROOM 213 City: BOSTON State or Province: MA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: STANFORD UNIVERSITY

Undergraduate School Address: STANFORD, CALIFORNIA 94305

(Continued on pa

Enrollment and Participation: Our records indicate that

Washington Sierra

(type or print the applicant's name): (Last name) (First name) (Middle initi

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:

FROM	TO	FROM	
9 / 2 / 99	6 / 16 / 00	7 / 1 / 02	6 /
8 / 28 / 00	5 / 21 / 01	7 / 1 / 03	6 /
7 / 1 / 01	6 / 30 / 02	7 / 1 / 04	6 /

The applicant attended 216 **total weeks *or*** _____ **total months (must be included) of not less than 32 weeks in each acad of continuing on-camous education.**

check one [X] was awarded a degree in M.D. on (month/day/year) 6 / 9

[ ] was NOT awarded degree. Please explain reason(s).

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's

All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

YES

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature:

Print Name: Terese Galuszka

Title: Registrar

Date: 1 / 12 / 12 Telephone: (617) 432-

This form will not be accepted unless it is stamped with the institutional seal or notarized.

MEDICARE TAX FORM

Commonwealth of Massachusetts--Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, SIERRA WASHINGTON,
(type or print name)

certify, under the penalties of perjury, to the best of my knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: ____________ DATE: 12/20/11

Social Security Number: ____________

* * *

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.04 (2) (k) require that you complete the following statement:

I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: ____________ DATE: 12/20/11

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CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for a substantial period of time and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH

ted.

ıe

Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

Signature of Notary

27 February 2015
My commission expires

KATHRYN G. KEMPTON AMARAL
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 27, 2015

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

SIERRA WASHINGTON
(name of applicant)

for 12 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

x Joia Mukherjee
Signature of Certifying Physician

155853 — License Number
MA — State

JOIA MUKHERJEE
Type or print name clearly

Address: 888 COMMONWEALTH AVE
City: BOSTON
State: MA Zip: 02215
Telephone: (617) 998-0181
X Date: 1/3/2010

***Instructions to the certifying physician**: Return the completed form to the applicant **in a sealed envelope with your signature across the seal**.*

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MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: None From: 8 / 09 To: 10 / 10
City: Out of County - Kenya State: — Policy Number: —

Liability Carrier: None. From: 11 / 10 To: 4 / 11
City: Out of County - Kenya State: — Policy Number:

Liability Carrier: None From: 6 / 11 To: 9 / 11 ; 11/11 → present
City: Out of County - Kenya State: Policy Number:

Applicant's signature: [signature] 23 / 1 / 2012 Date

Print Name:
Address: City:
State: Zip code:

Additional forms available at the Board's website at www.massmedboard.org

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MALPRACTICE HISTORY

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3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
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Liability Carrier: UCSF RISK MANAGMENT OFFICE From: 6/05 To: 8/09
City: SAN FRANCISCO State: CA Policy Number:

Liability Carrier: From: / To: /
City: State: Policy Number:

Liability Carrier: From: / To: /
City: State: Policy Number:

Applicant's signature: [signature] 1/5/12
Date

Print Name: Washington, Siena
Address: 888 Commonwealth Ave 3rd Flr City: Boston
State: MA Zip code: 02215

Additional forms available at the Board's website at www.massmedboard.org

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City: SAN FRANCISCO State: CA Policy Number:

Liability Carrier: From: ___/___ To: ___/___
City: State: Policy Number:

Liability Carrier: From: ___/___ To: ___/___
City: State: Policy Number:

Applicant's signature: [signature] 1/5/12
Date

Print Name: Washington, Siena

Address: 888 Commonwealth Ave 3rd Flr City: Boston

State: MA Zip code: 02215

Additional forms available at the Board's website at www.massmedboard.org

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: medical protective company From: 9/16/11 To: 10/31/11
City: Fort Wayne State: IN Policy Number: 400310

Liability Carrier: medical protective company From: 4/15/11 To: 6/3/11
City: Fort Wayne State: IN Policy Number: 400310

Liability Carrier: medical protective Company From: 10/1/10 To: 11/1/10
City: Fort Wayne State: IN Policy Number: 400310

Applicant's signature: [signature] 1/5/12
Date

Print Name: SIERRA WASHINGTON

Address: 888 Commonwealth ave City: Boston

State: MA Zip code: 02215

Additional forms available at the Board's website at www.massmedboard.org

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as r
Massachusetts Board of Registration in Medicine.

Applicant's Signature: S Washington Date

Print or Type Name: Sierra Washington

Name of Institution: University of California, San Francisco

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of California, San Francisco (UCSF

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Sierra Washington (Print applicant's name) participated

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	A (ACC or
Internship	1	OB/GYN	6/21/05	6/20/06	yes	AC
Residency	2	OB/GYN	6/21/06	6/20/07	yes	AC
Residency	3	OB/GYN	6/21/07	6/20/08	yes	AC
Residency	4	OB/GYN	6/21/08	6/20/09	yes	AC

POSTGRADUATE V

APPLICANT'S NAME: Sierra Washington

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's
Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other:

COMMENTS:

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature:

Print Name: Amy M. Autry, MD

Academic Title: Program Director

Telephone: (415) 476-5192 Today's Date: 1/1

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YO ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 1/12
INITIALS: GH

Amended 2/12 CH

SIERRA WASHINGTON MD. Msc

EDUCATION & CERTIFICATION

12/2011	American Board of Obstetrics and Gynecology Certification
6/2008-6/2009	Chief Resident in OBGYN at University of California at San Francisco, Department of OBGYN and Reproductive Sciences, San Francisco, CA, USA.
6/2005-6/2008	Post Graduate Residency in OBGYN at University of California at San Francisco, Department of OB, GYN and Reproductive Sciences, San Francisco, CA, USA.
9/1999-6/2005	Doctor of Medicine at Harvard Medical School, Boston, MA, USA.
9/2002-9/2003	Master of Science, London School of Hygiene and Tropical Medicine, London, UK.
8/1994- 6/1998	Bachelor of Arts, Stanford University, Stanford, CA, USA.

PROFESSIONAL EXPERIENCE

Co-Field Director Reproductive Health- Kenya

Academic Model for Prevention and Access to Health Care (AMPATH)
August 2009 – October 2011
AMPATH is a non-profit organization that provides health care across 56 rural health centers in western Kenya. My work as Co-Field Director for Reproductive Health focuses on four key areas. First: I co-direct the Prevention of Mother To Child Transmission of HIV program in all AMPATH facilities. Second: I co-direct the scale up a cervical cancer screening programming using VIA and Cryotherapy. Third I co-direct a program to integrate contraceptive services into our HIV care and treatment program. Fourth: I provide technical advise on a primary health care program aimed at decreasing maternal mortality.

Assistant Clinical Professor Indiana USA

Indiana University School of Medicine, Department of OBGYN, IU Kenya Program.
August 2009 – October 2011
Duties included clinical work at Moi Teaching and Referral Hospital (MTRH) in western Kenya and at Wishard Memorial Hospital in Indianapolis Indiana. Clinical duties include direct patient care in general Obstetrics and Gynecology as well as training and supervision of medical students and residents.

MTCT- Plus Project Manager & PEPFAR

Center for Infectious Disease Research in Zambia, Lusaka, Zambia.
January 2004 - December 2004.
MTCT-plus was one of the first HIV care and treatment programs in Sub-Saharan Africa. I Managed MTCT-plus in Lusaka, Zambia and assisted in the rapid scale up of ARV treatment clinics in 10 clinics under President Bush's Emergency Plan for AIDS Relief.

Program Officer -Zambia

My responsibilities included supervising the set-up of ARV clinics, coordination of clinical staff training, supervision of patient care and clinic management, design of adherence support systems, laboratory transport systems, and community outreach.

Research Intern -Zambia

Center for Infectious Disease Research in Zambia, Lusaka, Zambia.
June 2003 - August 2003.
I conducted qualitative research on social barriers to access to prevention of maternal-to-child transmission of HIV services in Lusaka, Zambia.

Paul Dudley White Fellow -Cameroon

Cameroon Baptist Convention Health Board, Cameroon.
June 2002 - August 2002.
I was the Program Coordinator for latent Tuberculosis (TB) screening and treatment program for HIV positive pregnant women in Cameroon.

Paul Dudley White Fellow -Zambia

Zambia Integrated Health Project, Lusaka, Zambia.
July 2000 - September 2001.
I Produced and directed a documentary video entitled 'Mutule' about HIV/AIDS among urban teenagers. The video was written and filmed by street youth in Lusaka and will be used nationally in Zambia to educate youth about AIDS. Work included: coordinating with the ministry of health, private industry and NGO's; conducting focus groups with youth to develop themes and scripts; development of an HIV knowledge, attitudes, and practices questionnaire; teaching HIV education; training youth on video and audio recording; video production and editing.

Albert Schweitzer Fellowship - Boston

"Girl Power" at Prevention Now! After School Program, Boston, MA.
December1999 - December 2000.
I was the founder and coordinator of an after-school curriculum that focuses on creating a strong community of adolescent girls and fostering interest in science and health among poor Black and Latino pre-adolescent girls in Boston.

Program Coordinator

Stanford Health Careers Opportunity Program (HCOP), Stanford University, CA.
June 1998 - August 1998.
Coordinated the HCOP program for disadvantaged minority students interested in a career in medicine.

Research Intern

Pasteur Institute, Paris, France.
March 1996 - June 1996.
I was a full time research intern in a viral immunology lab researching the mutagenisis of IkB and NFkB (nuclear factors) involved in providing resistance to HIV infection in simian and human T cells.

PEER REVIEWED SCHOLARLY PUBLICATIONS AND PRESENTATIONS

Washington S, Caughey AB, Cheng Y, Bryant A. Racial/ethnic differences in indication for primary cesarean delivery at term: experience at one U.S. institution. Birth. *In Press*

Vo B, Cohen CR, **Washington S**, Smith R, Bukusi E, Onono M, Doolan K, Turan J, Patient Satisfaction with Integrated HIV and Antenatal Care Services in Rural Kenya. AIDS Care. *In Press*

Washington S, Chirchir A. Opt Out Family Planning Counseling as Part of Routine HIV Care Contraception 2011; Sept 84(3):326-327

Shelly J, Romack B, Kuhn S, **Washington S**, Nabwire M, Pastakia. The Purdue Kenya Program: Emergency Medical Kits. (Poster Presentation) Purdue University's 4th Annual Scholarship of Engagement Conference. October 2010.

Cohan D, Gomez E, Greenberg M, **Washington S**, Charlebois ED. Patient perspectives with abbreviated versus standard pre-test HIV counseling in the prenatal setting: a randomized-controlled, non-inferiority trial. PLoS One 2009; 4(4):e5166.

Bryant AS **Washington S**, Kuppermann M, Cheng YW, Caughey AB. Sep;23(5):454-62. PPE. Quality and equality in obstetric care: racial and ethnic differences in caesarean section delivery rates. Paediatric Perinatal Epidemiology 2009; Sep 23(5):454-62.

Cantrell RA, Sinkala M, Megazinni K, Lawson-Marriott S, **Washington S**, Chi BH, et al. A pilot study of food supplementation to improve adherence to antiretroviral therapy among food-insecure adults in Lusaka, Zambia. J Acquir Immune Defic Syndr 2008 Oct 1;49(2):190-195.

Washington S, Bryant A, Kaimal A, Cheng Y, Caughey AB. Racial/Ethnic variation in medical indications for cesarean delivery may explain disparities in cesarean delivery risk. (Poster Presentation) Society for Maternal Fetal Medicine, 27th annual Scientific Meeting, 2007.

Bryant A, **Washington S**, Kaimal A, Cheng Y, Caughey AB. Cesarean delivery risk as a metric of racial/ethnic disparities in obstetrical care: The risk of cesarean delivery among low risk multiparas is highest for Black women. (Poster Presentation) Society for Maternal Fetal Medicine, 27th annual Scientific Meeting, 2007.

Megazzini K, **Washington S**, Sinkala M, Lawson-Marriott S, Stringer E, Krebs D, Levy J, Chi B, R. Cantrell, I. Zulu, L. Mulenga. A pilot randomized trial of nutritional supplementation in food insecure patients receiving antiretroviral therapy (ART) in Zambia (Oral Presentation-Abstract no. MOAB0401). The XVI International AIDS Conference, 2006.

S **Washington S**, Welty TK, Gideon F, Proctor MH. TB Screening of Women in the Peripartum Period in Cameroon, West Africa (Poster Presentation). *C01 : Epidemiology / Tuberculosis in high burden countries* 36th Union World Conference on Lung Health, 2005.

Washington S, Bond G. Barriers to uptake of prevention of mother-to-child transmission of HIV services in Lusaka, Zambia: a qualitative study (Poster presentation- Abstract no. TuPeD5036). The XV International AIDS Conference, 2004.

HONORS / AWARDS

1998	Golden Award for Excellence in Arts $ 15,000
2000	Paul Dudley White Fellowship $ 20,000
2000	Collins Award for Art in Medicine $20,000
1999	Albert Schweitzer Fellowship $5,000
2003	Kaiser Fund Scholarship for Study of International health $30,000
2004	Community service in Medicine Award
2005	UCSF Medical Student Teaching Award

SKILLS SUMMARY

* French as a second language
* Spanish as third language
* Swahilli as a third language
* Experience working in the public health sector
* Ability to work independently and as part of a team
* Experience working with people of diverse cultural backgrounds
* Proficiency in the following statistical programs: Stata, Ep-iinfo, Excel

REFERENCES

Astrid Christoffersen-Deb MD, PhD
Co-Field Director for Reproductive Health
AMPATH Consortium
Lecturer University of Toronto Faculty of Medicine
astridcdeb@gmail.com
astrid.cdeb@utoronto.ca
+254 728908167

Meg Autry, MD
Professor
Residency Director
Department of Obstetrics Gynecology and Reproductive Sciences
University of California
autrym@obgyn.ucsf.edu
(415) 353-7341

Elizabeth Stringer MD
MTCT Plus Country Director CIDRZ
5977 Mwembeshi Road

SUPPLEMENT FORM

PRINT NAME: SIERRA WASHINGTON DATE: 12/20/11

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: SWash Date: 12/20/11

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: _____ **Date:** 12 / 20 / 11

Revised: 12.01.10

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the supplemental pages for questions #16-A to 19. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years of this application.

		YES	NO
16-A.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
16-B.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
17-A.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently impaired or limited?		
17-B.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
18.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
19.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 1-19 change while your application is pending, you must immediately notify the Board of the new information.

Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)

Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting Child Support.

Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for full licensure in Massachusetts.

I certify under the penalties of perjury that all information on this form (front and back, and all attached pages) is true, to the best of my knowledge.

I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Applicant's Signature: _____ **Date:** 12/20/11

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - www.massmedboard.org

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, SIERRA WASHINGTON
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency, (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other documents, concerning my professional qualifications and competency, ethics, character, and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Applicant's Signature

12/20/11
Date of Signature

WASHINGTON, SIERRA LI'EN
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov

January 05, 2012

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:	SIERRA LI'EN WASHINGTON
LICENSE NUMBER:	A99781
ISSUED:	April 20, 2007
EXAM TYPE:	A Written Examination
EXPIRATION DATE:	October 31, 2012
STATUS:	RENEWED/CURRENT
BOARD DISCIPLINE:	No

This license information was last updated on: 01/04/2012

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

Curtis J. Worden

Curtis J. Worden
Chief of Licensing

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	Sierra Li'en Washington
Address:	Indiana University Hospital - Dept OBGN 550 N University Blvd. UH 2440 Indianapolis, IN 46202
Date of Birth:	10/24/1976

License Information

Number Issued:	01068175A
License Type:	Physician
Status:	Active
Issue date:	05/05/2010
Expiration Date:	06/30/2013
Obtained By:	Endorsement
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Mon Feb 06 12:43:15 PM EST 2012

UNITED STATES POSTAL SERVICE

Electronic Postmark

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St., Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: Sierra Li'en Washington

I, Frances Kelly, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature

If you have the need to verify the authenticity of the digital certification as of the date and time stamp below, go to https://secure.in.gov/apps/pla/verify.htm and use our free web service to "Verify an Electronic Certified Record". Simply browse to the location you saved the secure pdf document sent to you and upload to validate.

Frances Kelly

Frances Kelly, Executive Director
Mon Feb 06 12:43:15 PM EST 2012

UNITED STATES POSTAL SERVICE

Electronic Postmark

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	Sierra Li'en Washington
Address:	Indiana University Hospital - Dept OBGN 550 N University Blvd. UH 2440 Indianapolis, IN 46202
Date of Birth:	12/24/1976

License Information

Number Issued:	01068175A
License Type:	Physician
Status:	Active
Issue date:	05/05/2010
Expiration Date:	06/30/2013
Obtained By:	Endorsement
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Thu Jan 05 03:48:24 PM EST 2012

UNITED STATES POSTAL SERVICE

Electronic Postmark

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: Sierra Li'en Washington

I, Frances Kelly, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature

If you have the need to verify the authenticity of the digital certification as of the date and time stamp below, go to https://secure.in.gov/apps/pla/verify.htm and use our free web service to "Verify an Electronic Certified Record". Simply browse to the location you saved the secure pdf document sent to you and upload to validate.

Frances Kelly

Frances Kelly, Executive Director
Thu Jan 05 03:48:24 PM EST 2012

UNITED STATES POSTAL SERVICE

Electronic Postmark

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

Sierra L Washington M.D.
888 Commonwealth Ave, 3rd Floor
Attn: Sarah Roberto
Boston, MA 02215

10/25/2012

LICENSE EXPIRATION DATE: 10/24/2012 LICENSE # 250359

Dear Dr. Washington :

Please be advised that your license to practice medicine is now lapsed and you cannot practice medicine in the Commonwealth of Massachusetts unless you revive your license.

If you wish to revive your license, you must complete a lapsed license application which is available at the Board's website at www.mass.gov/massmedboard or by request from the Board. Your license revival must be approved by the full Board. The fee for revival of your license is $700.00 and the term of your license period will extend until your next birthday. At that time, you would be required to submit a complete standard two-year license renewal application.

Practicing medicine with an expired license is a criminal offense and in violation of M.G.L.c.112 §5 and the Board's regulation 243 CMR 1.05(5). Physicians who engage in the practice of medicine with an expired license must be reported to the Attorney General and may be subject to disciplinary action by the Board.

If you have any questions about these procedures, please call the Licensing Division at (781) 876-8210.

Sincerely,

Rose M. Foss

Rose M. Foss, Director
Licensing Division

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

Sierra L Washington M.D.
888 Commonwealth Ave, 3rd Floor
Attn: Sarah Roberto
Boston, MA 02215

10/25/2012

LICENSE EXPIRATION DATE: 10/24/2012 LICENSE # 250359

Dear Dr. Washington :

Please be advised that your license to practice medicine is now lapsed and you cannot practice medicine in the Commonwealth of Massachusetts unless you revive your license.

If you wish to revive your license, you must complete a lapsed license application which is available at the Board's website at www.mass.gov/massmedboard or by request from the Board. Your license revival must be approved by the full Board. The fee for revival of your license is $700.00 and the term of your license period will extend until your next birthday. At that time, you would be required to submit a complete standard two-year license renewal application.

Practicing medicine with an expired license is a criminal offense and in violation of M.G.L.c.112 §5 and the Board's regulation 243 CMR 1.05(5). Physicians who engage in the practice of medicine with an expired license must be reported to the Attorney General and may be subject to disciplinary action by the Board.

If you have any questions about these procedures, please call the Licensing Division at (781) 876-8210.

Sincerely,

Rose M. Foss

Rose M. Foss, Director
Licensing Division

CERTIFIED MAIL, RETURN RECEIPT REQUESTED