Uniform Application for Physician Licensure

UA Username silwash **Date Submitted** 2/23/2010
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Washington
First Name Sierra Li`en
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Business
[X] **Public Access**
[X] **Mailing**

Street Indiana University Hospital Dept OB/GYN
550 N. University Blvd. UH 2440
City Indianapolis **State/Province** IN **Zip Code** 46202
Telephone [redacted]
Fax 317-944-7417
Email [redacted]
Alternate Phone

Home
[ ] **Public Access**
[X] **Mailing**

Street Indiana University Hospital Dept OB/GYN
550 N. University Blvd. UH 2440
City Indianapolis **State/Province** IN **Zip Code** 46202
Telephone [redacted]
Fax 317-944-7417
Email [redacted]
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

10/24/1976	Nelson	British Columbia	Canada
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	[redacted]	1386845162		
Gender	Social Security Number	NPID	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** Harvard Medical School
Address 25 Shattuck Street

City Boston
State/Province MA
ZIP Code 02115
Country USA
Attendance Dates **From (mm/yyyy)** 09/1999 **To (mm/yyyy)** 06/2005
Graduation Date 6/9/2005
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name University of California, San Francisco
Hospital Address 505 Parnassus Ave
box 0132

City San Francisco
State/Province California
ZIP Code 94117
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 06 /2005 **To:** 06 /2009 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 3		06/2006	☒ P	☐ F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure - MD or DO only - attach additional pages if necessary

1	**State/Province**	CA	**Type** (MD, DO, etc)	MD	**License Number**	A99781	**Status**	In Good Sta	**Issue Date**	4/20/2007
2	**State/Province**	HI	**Type** (MD, DO, etc)	MD	**License Number**	MDR-5442	**Status**	Other	**Issue Date**	5/5/2008

10. Chronology of Activities: List ALL activities (medical and non-medical) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 2009 To: Month: 06 Year: 2009 In Progress ☐	**Practice/Employment Name** Vacation (or list non-working time as indicated above) **Practice/Employment Address** 1401 Shrader st **City** San Francisco **State/Province** California **ZIP Code** 94117 **Country** USA **Position and Department** Vacation-N/A **% Clinical** **% Administrative** 100 **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** Vacation

Dates: From/To	Practice/Employment
2 From: Month: 06 Year: 2005 To: Month: 06 Year: 2009 In Progress ☐	**Practice/Employment Name** Resident in Obstetrics and Gynecology (or list non-working time as indicated above) **Practice/Employment Address** UCSF 505 Parnassus Ave **City** San Francisco **State/Province** California **ZIP Code** 94117 **Country** USA **Position and Department** Resident-Obstetrics and Gynecol **% Clinical** 100**% Administrative** **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 07 Year: 2009 To: Month: 08 Year: 2009 In Progress ☐	**Practice/Employment Name** Clinical Instructor (or list non-working time as indicated above) **Practice/Employment Address** UCSF 505 Parnassus Ave **City** San Francisco **State/Province** California **ZIP Code** 94117 **Country** USA **Position and Department** Clinical Instructor-Obstetrics and (**% Clinical** 100**% Administrative** **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 08 Year: 2009 To: Month: Year: In Progress ☒	**Practice/Employment Name** Indiana University Department of Obstetrics and Gynecology (or list non-working time as indicated above) **Practice/Employment Address** Indiana University Hospital Department of Ob/Gyn 550 N. University **City** Indianapolis **State/Province** Indiana **ZIP Code** 46202 **Country** USA **Position and Department** Assistant Clinical Professor-Obste **% Clinical** 50 **% Administrative** 50 **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event: