Medical Licensing Board of Indiana

Addendum Instructions

Addendum Instructions: Complete the addendums as instructed below. Please type or print your responses. Return the completed addendums and this cover page along with any and all supporting documentation to the Indiana Board.

✓ **Addendum 1:** These questions must be completed by the applicant. Any "yes" responses to questions 1-10 will need additional documentation as explained in the form.

✓ **Addendum 2:** The completion of this form is **voluntary** and will **NOT** affect your application in any way.

Applicant's Name Sierra Li'en Washington

Signature SWashington

Date 2/8/2010

Please return a copy of the application, completed addendums and payment to the:

Medical Licensing Board of Indiana
402 West Washington Street, Room W072
Indianapolis, IN 46204

FOR OFFICE USE ONLY	
Application fee 250.00	**Date fee paid** *(month, day, year)* 2-25-2010
Receipt number 3202392	**Application number**
License number 01068175A	**License issuance date** *(month, day, year)* 5-5-10
Permit fee	**Date fee paid** *(month, day, year)*
Receipt number	**Permit number**
Permit issuance date *(month, day, year)*	

Addendum 1

Answer the following questions. For questions 1-10: If your answer is "Yes" to any of these questions, explain fully in a signed, sworn and notarized affidavit, including all related details. Include the violation, location, date and disposition. If applicable, please submit copies of all court documents and/or arrest records. **If malpractice, complete the "Malpractice Liability Claims Information" section of the Online Uniform Application for Physician State Licensure (UA) for each claim.** Letters from attorneys or insurance companies are not accepted in lieu of your statement, but may be submitted with your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

☐ Yes ☑ No 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?

☐ Yes ☑ No 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country, or surrendered your license?

☐ Yes ☑ No 3. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction?

☐ Yes ☑ No 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?

5. Have you ever been convicted of, plead guilty or *nolo contendere* to, or are charges pending:

☐ Yes ☑ No A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?

☐ Yes ☑ No B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*)

☐ Yes ☑ No 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?

☐ Yes ☑ No 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?

☐ Yes ☑ No 8. Have you ever had a malpractice judgment against you or settled any malpractice action?

☐ Yes ☑ No 9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?

☐ Yes ☑ No 10. Have you ever been disciplined by your employer while practicing as a physician or resigned in lieu of discipline?

Temporary Permit Information:

11. Do you desire a temporary permit? ☐ Yes ☑ No
If yes, an additional fee of $100 is required.

FEB 25 2013

List any Specialties / Board Certification:

12. Specialties: OB GYN

13. Board Certification (list ABMS certification): _____

Addendum 2

VOLUNTARY RACE / ETHNICITY / GENDER QUESTIONS**

This information is completely voluntary and will NOT affect your application in any way.

Applicant Name: Washington (Last) Sierra (First) Lien (Middle)

1. **Ethnicity:** African American

2. **Race:** _____

3. **Gender:** ☐ Male ☒ Female

** Note: This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

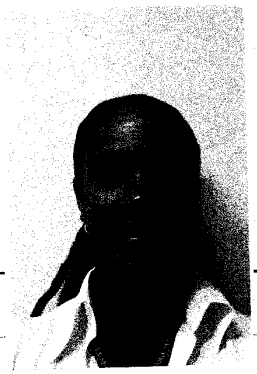
I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Sierra Washington
Applicant's Signature (must be signed in the presence of a notary)

Washington
Applicant's Printed Last Name

Sierra L.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

2/23/10
Date of Signature



NOTARY

Dated 2/23/10 Signed Chris A. Davis-Wallace

State of INDIANA County of MARION

SUBSCRIBED AND SWORN TO before me this 23 day of, February 2010.

My commission expires: 01/01/16 (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: washington, Sierra, Li'en Date:

UA User : silwash

FEB 25 2010

Gender F

4. Medical Education

School Name: Harvard Medical School
Attendance Dates : 09/1999 - 06/2005
Date Degree Conferred/Issued: 06/09/2005
Type of Degree: Doctor of Medicine

5. Fifth Pathway

6. Postgraduate Medical Education

Hospital Name : University of California, San Francisco
Address : 505 Parnassuss Ave
San Francisco, CA 94117
USA
Post Graduate Year : Internship/Residency
Accredited By : ✓
Department/Specialty : Obstetrics and Gynecology
Rotation Dates : 06/2005 - 06/2009
Successfully Completed? : Y

7. Examination History

Exam	State	Date	(P)ass/(F)ail	Attempts
USMLE Step 3		06/2006	P	1

8. ECFMG

Certificate Number :
Issue Date :
Valid Through Date :

9. State or Professional Licensure

Type	Other Type	State	Number	Status	Issue Date
Doctor of Medicine		California	A99781	In Good Standing	04/20/2007
Doctor of Medicine	Expired	Hawaii	MDR-5442	Other	05/05/2008

10. Chronology of Activities

Type of Activity: Work
Start Date: 06/2005 **End Date:** 06/2009
Practice/Employment Name: Resident in Obstetrics and Gynecology
Address: UCSF
505 Parnassus Ave
San Francisco, CA 94117
USA
Position: Resident
Department: Obstetrics and Gynecology
% Clinical: 100 **% Administrative:**
Employment: Y **Staff Privileges:** N **Affiliation:** N **Other:**

Type of Activity: Vacation
Start Date: 06/2009 **End Date:** 06/2009
Practice/Employment Name: Vacation
Address: 1401 Shrader st
San Francisco, CA 94117

Uniform Application for Physician State Licensure

Navigation Options:

Welcome Sierra, Li'en washington! Login

State Instructions | Personal Information | Education & Certification | Licensure & Employment | Malpractice & Liability | Review & Submit | Forms & Affidavit

Review & Submit

Please review all of you entries prior to submission: If you see anything you need to correct, you can navigate back to that section by using the navigation above. **It is strongly advised that you print a copy for your records.**

When the applicant clicks submit, the Federation will forward this application, a board action report and a licensure history report to the Board for their application approval procedure. If the applicant has questions at this point, the applicant will need to address those questions directly with the Board.

Uniform Application for Physician State Licensure - Self-Reported

UA Username: silwash Submitted on: Pending

1. Name

Name Sierra, Li'en Washington, M.D.
Maiden Name
Alternate Name(s)

2. Address/Phone

Practice Address : Indiana University Hospital, Dept:OBGYN
550 N. University Blvd. UH 2440
Indianapolis, IN 46202
USA
Public Access: Y **Mailing:** N

Home Address: Indiana University Hospital, Dept: OBGYN
550 N. University Blvd. UH 2440
Indianapolis, IN 46202
USA
Public Access: N **Mailing:** Y

RECEIVED
FEB 25 2010
Indiana Professional Licensing Agency

Business Phone: 317-944-1661 **Business Fax:** 317-944-7417
Home Phone: [redacted] **Home Fax** 317-944-7417

Primary Email: [redacted]
Secondary Email:

3. Identification

Birth Date 10/24/1976
Location: Neslon, BC
Canada
SSN [redacted]
National Provider ID 1386845162
U.S. Citizen Y

USA
Position: Vacation
Department: N/A
% Clinical: **% Administrative:** 100
Employment: N **Staff Privileges:** N **Affiliation:** N **Other:** Y (Vacation)

Type of Activity: Work
Start Date: 07/2009 **End Date:** 08/2009
Practice/Employment Name: Clinical Instructor
Address: UCSF
505 Parnassus Ave
San Francisco, CA 94117
USA
Position: Clinical Instructor
Department: Obstetrics and Gynecology
% Clinical: 100 **% Administrative:**
Employment: Y **Staff Privileges:** N **Affiliation:** N **Other:**

Type of Activity: Work
Start Date: 08/2009 **End Date:**
Practice/Employment Name: Indiana University Department of Obstetrics and Gynecology
Address: Indiana University Hospital
Department of Ob/Gyn 550 N. University
Indianapolis, IN 46202
USA
Position: Assistant Clinical Professor
Department: Obstetrics and Gynecology
% Clinical: 50 **% Administrative:** 50
Employment: Y **Staff Privileges:** N **Affiliation:** N **Other:** N

11. Malpractice Liability Claims Information

If you have completed all necessary pages of your application, and printed the appropriate forms you need to send out, use the "Submit Application" button below. An electronic version of your application will be available to the licensing agency immediately.

NOTE: Once you submit your application, no changes can be made to that particular copy that is sent. A copy of your information will be available if you need to send your application to another licensing agency.

When the applicant clicks submit, the Federation will forward this application, a board action report and a licensure history report to the Board for their application approval procedure. If the applicant has questions at this point, the applicant will need to address those questions directly with the Board.

SUBMIT APPLICATION

UCSF
University of California
San Francisco

Obstetrics, Gynecology & Reproductive Sciences

Amy (Meg) Autry, MD
Clinical Professor
Residency Program Director

505 Parnassus Ave., Box 0132
San Francisco, CA 94143
Tel: 415-476-5192
Fax: 415-476-1811
Autrym@obgyn.ucsf.edu

February 3, 2010

To: Indiana Professional Licensing Agency
Medical Licensing Board
402 W. Washington Street
Room W072
Indianapolis, IN 46204

Re: Dr. Sierra Washington

Dr. Sierra Washington successfully completed the UCSF OB/GYN residency program in June 2009. She began her residency on June 21, 2005 and finished on June 20, 2009. During her residency, Dr. Washington was a resident in good standing.

Amy (Meg) Autry, MD
Professor
Residency Program Director

STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944

www.mbc.ca.gov

March 4, 2010

INDIANA HEALTH PROFESSIONS BUREAU
402 W WASHINGTON ST RM W072
INDIANAPOLIS IN 46204

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 No.:	A 99781
Issued:	April 20, 2007
Exam Type:	A written examination
Expiration Date:	October 31, 2010
Status:	Renewed/current
Board Discipline:	NO

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

Deborah Pellegrini

Deborah Pellegrini
Chief of Licensing

SEAL

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
P.O. BOX 3469
HONOLULU, HAWAII 96801

03/15/10

IN MEDICAL LICENSING BOARD
402 W WASHINGTON ST
INDIANAPOLIS IN 46204

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 03/01/10 FOR
SIERRA WASHINGTON

BOARD/COMMISSION:	HAWAII MEDICAL BOARD
LICENSE TYPE:	PHYSICIAN-RESIDENT
LICENSE IDENTIFICATION:	MDR 5442
METHOD OF LICENSURE:	EXECUTIVE/BOARD APPROVAL NEEDED
DATE LICENSED:	05/05/08
LICENSE STATUS:	EMPLOYER RELEASES AN EMPLOYEE
LICENSE EXPIRATION DATE:	06/20/08
DISCIPLINARY ACTION:	NONE

ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

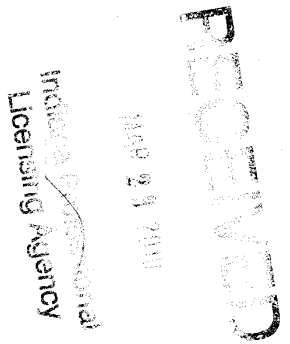
✓ NO DEROGATORY INFORMATION IS ON FILE.

__ THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

Constance C. Cabral

CONSTANCE CABRAL
EXECUTIVE OFFICER



The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Sierra Li En Washington**
SSN:	[redacted]
DOB:	**10/24/1976**
Packet ID:	**115255**
Recipient:	**Medical Licensing Board of Indiana**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Sierra Li En Washington**	
Other Name Used:	**Sierra Mariposa Li`en Washington**	
Gender:	**Female**	
Date of Birth:	**Not Reported by the Primary Source**	
Place of Birth:	**Not Reported by the Primary Source**	
SSN:	**102-82-9972**	
Current Address:	**Indiana University Hospital** **Department of Ob/Gyn** **550 North University Boulevard UH 2440** **Indianapolis, IN 46202**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	[redacted]
	Other:	**N/A**
Physical Description:	Height:	**5' 05"**
	Weight:	**170 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**Tattoo**
	Location:	**Back**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**Stanford University, Stanford, CA 94305-3005**
Dates of Attendance:	**08/1994 - 06/1998**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**Harvard Medical School** **25 Shattuck Street** **Boston, MA 02115-6092**
Dates of Attendance:	**09/02/1999 - 06/09/2005**
Date Degree Conferred/Issued:	**06/09/2005**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**University of California San Francisco** **Department of Obstetrics and Gynecology** **505 Parnassus Avenue** **Box 0132 M 1483** **San Francisco, CA 94143-0132**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/21/2005 - 06/21/2006**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-4**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/22/2006 - 06/20/2009**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Sierra Li En Washington
DOB:	10/24/1976
SSN:	[redacted]
Packet ID:	115255
Request ID:	21900218

OMISSIONS

Omission 1:

Section of Profile: **Identity**

Omission: The applicant was unable to provide a certified birth certificate or an original passport.

Follow-Up: FCVS obtained a photocopy of the identity document in lieu of the original. A written explanation from the applicant is included.

DISCREPANCIES

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: The applicant responded Yes to the `Leave` question in the Unusual Circumstances Section of the application for attendance at Harvard Med Sch. The institution responded No to all of the questions in the Unusual Circumstances Section of the Verification of Medical Education form.

Follow-Up: FCVS does not follow up with the applicant or the institution with discrepant information on Unusual Circumstances questions. Any supporting information provided by the applicant and/or institution is included in the Physician Information Profile.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Identity**

Issue: The applicant did not provide a photocopy of a birth certificate, passport, court order, baptismal certificate, naturalization certificate, marriage certificate or divorce decree to support alternate names, as requested by FCVS.

Follow-Up: FCVS has made several unsuccessful attempts to obtain documentation to support the alternate name from the applicant; the applicant was unable to provide one. In lieu of the document, FCVS obtained an explanation from the physician. See the Name Explanation Form included.

Miscellaneous 2:

Section of Profile:	**Post-Graduate Education**
Issue:	The applicant and University of California San Francisco do not report the same program types for 06/21/2005 to 06/21/2006.
Follow-Up:	FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident.).

End of report for Sierra Li En Washington

Packet Id: 115255 Request Id: 21900218 Report Created By: JAV

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 29, 2010

FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: April 29, 2010
Your Reference Number: FCVS-JAV
FSMB Batch Number: BQ1753757

The following is a final report of the search results from the Board Action Data Bank as of April 29, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 29, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
1	Washington, Sierra Li En	10/24/1976	022020	2005	22186938

LICENSE HISTORY
State Board
CALIFORNIA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 4/29/2010

State Queried For: Medical Licensing Board of Indiana

Physician Name: Sierra Li En Washington

Date of Birth:

Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Applicant's Signature (must be signed in the presence of a notary)

Washington
Applicant's Printed Last Name

Sierra Li'em
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

2/23/10
Date of Signature

10·24·1976
Date of Birth

[redacted]
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of INDIANA County of MARION

SUBSCRIBED AND SWORN TO before me this 23 day of February, 20 10

My commission expires: 01/01/2016

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: A. Davis-Wallace

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Federation of
STATE MEDICAL BOARDS

IDENTITY DOCUMENT

PROVIDED BY APPLICANT

I cannot provide a certified birth certificate or original un-expired passport, which is required by FCVS as valid documentation of identity. The following statement explains why I cannot provide the required document.

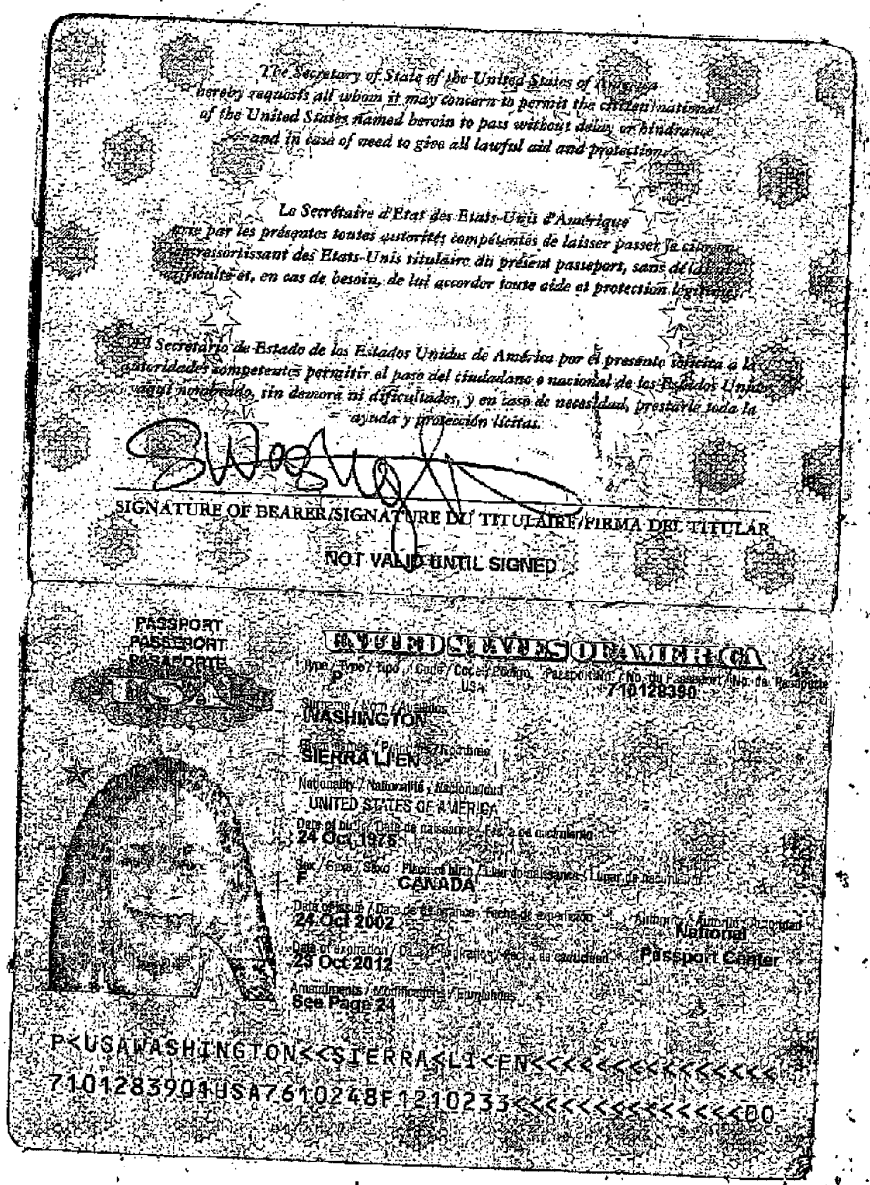
I am an American citizen, currently living in Kenya, I have my original US passport with me in Kenya because it has documentation of my Kenyan Work permit and Entry Visa. I am legally required to have my passport on me at all times while living in Kenya. Therefore I am unable to send you the original document. The notarized copy of my passport has already been forwarded to FVCS. My birth certificate is in Canada and I am unable to access these records while residing in Kenya.

Sierra Lien Washington
Name

115255
Packet ID

Signature

24/3/2010
Date



The Secretary of State of the United States of America
hereby requests all whom it may concern to permit the citizen/national
of the United States named herein to pass without delay or hindrance
and in case of need to give all lawful aid and protection.

La Secrétaire d'Etat des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer le citoyen/
ressortissant des Etats-Unis titulaire du présent passeport, sans délai
ni entraves et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las
autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos
aquí nombrado, sin demora ni dificultades, y en caso de necesidad, prestarle toda la
ayuda y protección lícitas.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT
PASSEPORT
PASAPORTE

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. du passeport / No. de Pasaporte: 710128390

Surname / Nom / Apellido: WASHINGTON

Given Names / Prénoms / Nombres: SIERRA LIEN

Nationality / Nationalité / Nacionalidad: UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento: 24 Oct 1978

Sex / Sexe / Sexo: F

Place of birth / Lieu de naissance / Lugar de nacimiento: CANADA

Date of issue / Date de délivrance / Fecha de expedición: 24 Oct 2002

Authority / Autorité / Autoridad: National Passport Center

Date of expiration / Date d'expiration / Fecha de vencimiento: 23 Oct 2012

Amendments / Modifications / Enmiendas: See Page 24

P<USAWASHINGTON<<SIERRA<LI<EN<<<<<<<<<<<<<<<<<<<<<<

7101283903USA7810248F1210233<<<<<<<<<<<<<<<00

Marjori Co,
True Copy of Original

Venus A. Davis-Wallace
Comm Exp 01/01/2016

EXPLANATION OF ALTERNATE NAME FORM

PROVIDED BY APPLICANT

Use this form to explain the use of any name(s) not supported by the identity document(s) submitted with your application. Do not write on the back of this form. If additional space is required, please make a photocopy(ies). Be certain to sign the form in the space provided at the bottom of the page

Identity Document Name The name reported here must be the name on your identity document.	Last Name: Washington Rest of Name: Sierra Li'en
Diploma	Last Name: Washington Rest of Name: Sierra Mariposa Li'en Explanation of Use of Name: **I have 2 middle names**
Diploma Translation	Last Name: Washington Rest of Name: Sierra Mariposa Li'enn Explanation of Use of Name **I have two middle names**
	Last Name: Rest of Name: Explanation of Use of Name:

Signature: [signature] **Date: 24/3/2010**

By typing my name above, I hereby certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Harvard Medical School

Complete Address: OFFICE OF THE REGISTRAR
HARVARD MEDICAL SCHOOL
25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115-6092

Street Address: _____

City: _____ **State:** _____ **ZIP Code (Postal Code):** _____

If name of institution was different when this individual attended, please note this name below:

_____

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: AB

Enrollment and Participation: Our records indicate that Washington, Sierra L
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 216 weeks of medical education on the following dates (mm/dd/yy):

From 9 / 2 / 1999 (Month / Date / Year) **To** 6 / 9 / 2005 (Month / Date / Year)

This individual (check one):

Was awarded the degree of MD on 6 / 9 / 2005 (Month / Date / Year)

Was NOT awarded a degree because: _____
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Terese Galuszka (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available this form must be notarized.

Signature: Terese Galuszka

Title: Registrar

Date of Signature: March 15, 2010

Phone: (617) 432-1515 **Fax:** (____) _____

Email: _____

K Dinkelacker

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)
(continued)

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
Response YES ☐ NO ☒

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Y:	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response YES ☐ NO ☒

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

_____

_____

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response YES ☐ NO ☒

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

_____

_____

Medical Education

PROVIDED BY APPLICANT

School	022020 - Harvard Medical School		
Address	25 Shattuck Street Boston, MA 02115 USA		
Phone	[redacted]		
Dates	09/1999 - 06/2005	**Grad Date**	06/09/2005
Degree	MD - Doctor of Medicine		
Program 6+ years:	N		

Completed clinical clerkship in a country other than where my medical school was located: Y

Clinical Training

Unusual Circumstances

Leaves/Extensions	Y	I took an additional year from 2003-2004 to complete a Masters of Science in Public Health at the London School of Hygiene and tropical Medicine. Then I took an additional year from 2004- 2005 to work in the field of Public Health. During that year I worked as a program manager for a large HIV treatment program in Zambia. I returned in January of 2005 completed my course work and graduated in June of 2005.
Probation	N	
Disciplined	N	
Negative Reports	N	
Limitations	N	

VNIVERSITAS HARVARDIANA

CANTABRIGIAE IN REPVBLICA MASSACHVSETTENSIVM

PRAESES et Socii Collegii Harvardiani consentientibus honorandis ac reverendis Inspectoribus in comitiis sollemnibus

SIERRA MARIPOSA LI'EN WASHINGTON
ad gradum Medicinae Doctoris

admiserunt eique dederunt et concesserunt omnia insignia et iura quae ad hunc gradum spectant.

In cuius rei testimonium litteris Academiae sigillo munitis die VIIII Iunii anno Domini MMV Collegiique Harvardiani CCCLXVIIII auctoritate rite commissa nomina subscripserunt.

Laurence H. Summers
PRAESES

Joseph B Martin
DECANVS ORDINIS MEDICINAE

True Copy of Original
6/11/10

SEAL VERIFIED

Marion Co.
Venus A. Davis-Wallace

HARVARD MEDICAL SCHOOL

OFFICE OF THE REGISTRAR

25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115-6092
Telephone (617) 432-1515

Translation of M.D. diploma

HARVARD UNIVERSITY IN CAMBRIDGE

The President and Fellows of Harvard College with the consent of the Honorable and the Reverend Board of Overseers, in solemn council assembled, have admitted

SIERRA MARIPOSA LI'ENN WASHINGTON

to the rank of Doctor of Medicine and have given her and conferred upon her rights and privileges belonging to this rank.

In testimony whereof, to these letters, authenticated by the seal of the University, the President, and Dean, by the authority rightfully committed to them have subscribed their names on the 9th of June in the year 2005 Harvard College the three hundred and seventy-five.

Lawrence H. Summers
President

Joseph B. Martin
Dean of the Faculty of Medicine

Section IV

Graduate Medical Education Training

Fe ıtion Credentials Verification Service (FCV

, ederation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **University of California San Francisco**

Address: **Department of Obstetrics and Gynecology**
San Francisco, CA 94143-0132

Attention: **Program Director**

Affiliated University: U.C.S.F.

RECEIVED
APR 23 2010
By

Verification For:

Name: **Washington, Sierra Li En**

DOB: **10/24/1976**

Individual's Name on Record (If different from above):

Program Participation: Important:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress, report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1

- [x] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty: OB/GYN

From: 6/21/2005 **To:** 6/21/2006

Successfully Completed?: Yes [x] No [ ] In Progress [ ]

Accredited by: ACGME [x] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these [ ]

PGY: 2 - 4

- [ ] Internship
- [x] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty: OB/GYN

From: 6/22/2006 **To:** 6/20/2009

Successfully Completed?: Yes [x] No [ ] In Progress [ ]

Accredited by: ACGME [x] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these [ ]

PGY: _____

- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty: _____

From: ___/___/___ **To:** ___/___/___

Successfully Completed?: Yes [ ] No [ ] In Progress [ ]

Accredited by: ACGME [ ] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these [ ]

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training?	Yes [ ] No [x]
2. Was this individual ever placed on probation?	Yes [ ] No [x]
3. Was this individual ever disciplined or placed under investigation?	Yes [ ] No [x]
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes [ ] No [x]
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes [ ] No [x]

Please explain any "YES" response from above:

SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only) or if appropriate, the Diretor of GME.

Name: Ann Megan Autry M.D. Signature:

Title: Program Director Date of Signature: 4/13/10

Tel: (415) 476-5192 Fax: (415) 476-1811 E-Mail: autrym@obgyn.ucsf.edu

KWINKLER

Rev. 05/22/07 Packet ID: 115255 Request ID: 21900218 FCVS [11320]

Postgraduate Medical Education

PROVIDED BY APPLICANT

Hospital	University of California, San Francisco
Affiliated School	
	505 Parnassus Ave
	box 0132
	San Francisco, CA 94117

Year(s)	1-4	**Program Type**	Residency
Complete?	Yes	**Specialty/Subspecialty**	Obstetrics and Gynecology
Dates	06/2005 - 06/2009		

Unusual Circumstances

Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N