STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2477
www.mbc.ca.gov

RECEIVED MEDICAL BOARD OF CALIFORNIA 2011 JAN 10 PM 3:45

EXAMINATION

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

Application for (please check one): ☑ License ☐ PTAL - or - ☐ Update

1. NAME : Last	First	Middle	MBC Use Only
Krishnan	Sheila		

Other names you have used (include maiden name):

2. U.S. Social Security Number: [redacted]

3. Place of Birth: [redacted]

4. Date of Birth: [redacted]

5. Gender: ☐ Male ☑ Female

Address Change

6. Public/Mailing Address: 33 West Ontario Street Apt 25C
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
Chicago	IL	60654	USA

7. Telephone Numbers: (include area code) Home: [redacted] Work: [redacted] Cell: [redacted]

8. California Driver's License Number (optional):

9. E-mail Address (optional): [redacted]

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?
☐ Yes ☑ No
Previous license number, if any: _____

Personal Data ☑

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
University of Michigan Medical School	Ann Arbor, MI, USA	8/2001 - 6/2005

L2 Transcript ☐ ☐ ☐ ☐ ☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation
University of Michigan Medical School	Doctor of Medicine (MD)	6/3/2005

Diploma ☑ ow

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
USMLE STEP 1	June 19, 2003	[redacted]
USMLE STEP 2 CK/CS	August 27, 2004 / November 29, 2004	
USMLE STEP 3	July 27, 2006	

Exams ☐ ☐ ☑

493 — 0013763 — JAN 10 2011 — Cashiering Use Only

MI 001 — School Code

L1A

07A-100 (Rev. 04/2008)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance
Beth Israel Deaconess Medical Center	330 Brookline Avenue Boston MA 02215	OB/GYN-resident	6/2005 – 6/2009
Northwestern University	680 N. Lakeshore Drive Chicago IL 60611	OB/GYN Fellow	7/2009 – present
*Note this not an ACGME approved Fellowship			

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	☑
Have you ever been terminated, dismissed or expelled from a program?	☑
Have you ever resigned from a training program?	☐
Were you ever placed on probation?	☑
Were you ever disciplined or placed under investigation?	☑
Were any incident reports ever filed by instructors?	☑
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	☐
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☑

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

APPLICANT: Sheila Krishnan

DATE OF BIRTH: [redacted]

L1B

ABMS CERTIFICATIONS

MBC Use Only

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☑
⇒ Active candidate for American Board of Obstetrics and Gynecology

ABMS ☑

Member Board	Expiration Date	Certificate Number	
American Board of Obstetrics and Gynecology	Passed Written Boards 01/28/2010 Need to complete Oral Boards by 01/28/2016	9016608	☐
			☐

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? ☐ ✓

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? ☑ ✓
19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? ☐ ✓
20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? ☐ ✓
21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? ☐ ✓
22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? ☐ ✓

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

CRIMINAL RECORD HISTORY

Criminal Record

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

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

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

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

APPLICANT:	DATE OF BIRTH:
Sheila Krishnan	[redacted]

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only

Criminal Record

24. Is any criminal action pending against you? ☑

25. Are you required to register as a Sex Offender? ☑

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? ☑

27. Is any denial pending against you? ☑

28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? ☑

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? ☑

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? ☑

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? ☑

32. Is any disciplinary action pending against any of your licenses to practice medicine? ☑

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? ☑

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? ☑

35. Is any disciplinary action pending against your hospital staff privileges? ☑

36. Have you ever surrendered a license to practice medicine? ☑

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? ☑

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? ☑

APPLICANT: Sheila Krishnan

DATE OF BIRTH: [redacted]

L1D

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, Sheila Krishnan (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. SK **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Sheila Krishnan
(Please sign full name – in presence of notary)

State of Illinois

County of Cook

Subscribed and sworn to (or affirmed) before me on this 18 day of January, 20 11, by Sheila Krishnan
(Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature Yolanda N. Buckley

"OFFICIAL SEAL"
YOLANDA N. BUCKLEY
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 9/23/2013

L1E

07A-100 (Rev. 09/2010)

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, Sheila Krishnan (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. SK **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Sheila Krishnan (Please sign full name – in presence of notary)

State of CA

County of ALAMEDA

Subscribed and sworn to (or affirmed) before me on this 28 day of 12, 20 10, by

MOHAMED SIDDIQUI - NOTARY PUBLIC (Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature [signature]

(seal)

MOHAMED AJAZ SIDDIQUI
COMM.# 1796194
NOTARY PUBLIC-CALIFORNIA
ALAMEDA COUNTY
My Comm. Exp. Feb. 22, 2012

L1E

07A-100 (Rev. 09/2010)

Consumer Affairs

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

TRANSCRIPT & CERTIFICATION UNIT 2010 DEC 21 AM 8:13

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Sheila Krishnan ; [redacted]
Full Name of Applicant U.S. Social Security Number

[redacted] enrolled in University of Michigan Medical School
Date of Birth Name of Medical School

located in Ann Arbor MI, USA on 08/21/2001.
State/Province Country Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality	Neurosurgery
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology, and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal Partner Abuse Detection & Treatment*
Dermatology	Preventative Medicine, including Nutrition	Family Medicine**
		Pain Management and End-of-Life Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

☒ was granted the degree of ~~Bachelor~~/Doctor of Medicine on the 03 day of June, 2005.

☐ withdrew from medical school on ____ day of _____, _____.

Unusual Circumstances

	Responses
Did this individual ever take a leave of absence from their medical education?	[redacted]
Was this individual ever placed on probation?	
Was this individual ever disciplined or under investigation?	
Were any incident reports regarding this individual ever filed by instructors?	
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	

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

Medical School Seal Must Be Impressed Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 13 day of December, 2010.
	Printed Name and Title of School Official: Paul Robinson, University Registrar
	Signature: [signature]

L2

07A-150-L2 (Rev. 08/2010)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last	First	Middle
Krishnan	Sheila	

U.S. Social Security Number	Date of Birth	Telephone Number
[redacted]	[redacted]	Home [redacted] Work

Public/Mailing Address: 33 West Ontario Street Apt 25C

City	State/Province	Zip/Postal Code
Chicago	IL	60654

Medical School of Graduation: University of Michigan Medical School

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility	ACGME 10-digit Program number (www.acgme.org)
Beth Israel Deaconess Medical Center	2202411123

Address of Facility	Telephone #
330 Brookline Ave., KS 319, Boston, MA 02215	[redacted]

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
OB/GYN	06/20/2005	06/19/2009

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from his/her training? [redacted]

Was the trainee ever terminated, dismissed or expelled?

Did the trainee ever resign?

Was the trainee ever placed on probation?

Was the trainee ever disciplined or placed under investigation?

Were any incident reports regarding this trainee ever filed by instructors?

Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?

Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?

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

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

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

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

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

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

☑ **has completed** ☐ **has not completed**

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

SIGNATURE OF PROGRAM DIRECTOR

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

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Hope Ricciotti, MD

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR — **DATE SIGNED** 12/13/10

Signature Stamp is Not Acceptable

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____

(Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____

(Notary to print director's name.)

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

Signature_____(seal)

L3B

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**117818**
File Number:	**94770**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14581344**
Application Date:	**11/04/2018 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**SHEILA**
Middle Name:	**KRISHNAN**
Last Name:	**MODY**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? [redacted]

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.

[redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - 10-19 Hours** **Teaching - 10-19 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: County: SAN DIEGO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County: SAN DIEGO**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**6 Years**
Cultural Background	[redacted]
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - Yes**
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**

Total Amount Due: **$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**117818**
File Number:	**94770**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14353896**
Application Date:	**10/27/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**SHEILA**
Middle Name:	**KRISHNAN**
Last Name:	**MODY**
Birthdate:	**/**/****
Gender:	[redacted]

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? [redacted]

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.

[redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 30-39 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 92103 County: SAN DIEGO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 92307 County: SAN DIEGO**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**

Total Amount Due: **$820.00**

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I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date: