ATS # 287645

MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION

(Please Check All That Apply)
- ☑ Physician's and Surgeon's License
- ☐ Postgraduate Training Authorization Letter (PTAL)
- ☐ Update Application: ATS #________
- ☐ Limited Practice License

(Please Check One)
- ☑ U.S. or Canadian Medical School Graduate
- ☐ International Medical School Graduate

Type or Print Legibly

PERSONAL INFORMATION

MBC Use Only

1. Legal Name	Last: *Chollet*	First: *Anna*	Middle: *Louise*
2. Other Names/Alias			
3. United States Social Security Number	[redacted]	4. Gender	☐ Male ☑ Female
5. Date of Birth (mm/dd/yyyy)	[redacted]	6. Place of Birth (City, State/Country)	[redacted]

7. Public/Mailing Address
If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.

Mailing Address (30 characters maximum per line, including spaces): *3569 Round Barn Circle Ste 200*
Mailing Address continued (30 characters maximum per line, including spaces):

City	State/Province	Zip/Postal Code	Country
Santa Rosa	*CA*	*95403*	*USA*

Personal Information

8. Telephone Numbers — Home #: [redacted] Work #: [redacted] Cell #: [redacted]

9. E-mail Address:

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied? [redacted] Yes [redacted] No

11. Have you previously held a Physician's and Surgeon's License in California? ☐ Yes ☑ No
If yes, please provide license number: ________ Expired: ________

Prev License

EXAMINATIONS

Exams

12. Have you ever been found to have engaged in irregular behavior during an examination? [redacted] Yes [redacted] No

13. Have you ever been subject to an investigation by an examination entity? [redacted] Yes [redacted] No

14. Are you certified by the Educational Commission for Foreign Medical Graduates? ☐ Yes ☑ No
If yes, please provide the Certificate Issue Date: ________

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**
(Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)
USMLE STEP 1	*05/2010*	[redacted]
USMLE STEP 2 CK	*08/2011*	[redacted]
USMLE STEP 2 CS	*10/2011*	[redacted]
USMLE STEP 3	*12/2012*	[redacted]

Cashiering Use Only

LA 001
School Code

L1A

MEDICAL EDUCATION

MBC Use Only

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our Web site at: http://www.mbc.ca.gov/applicant/schools_recognized.html.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		L2 / Trans / School Code
Tulane University SOM	*New Orleans, LA USA*	Start	*08/01/2008*	☒ ☒ LAN
		End	*06/08/2012*	
		Start		☐ ☐
		End		
		Start		☐ ☐
		End		

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma
Tulane University SOM	*M.D.*	*06/08/2012*	☒

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Question			Unusual Circumstances
18. Did you ever take a leave of absence during medical school?	Yes	No	☐
19. Were you ever placed on probation?	Yes	No	☐
20. Were you ever disciplined or placed under investigation?	Yes	No	☐
21. Were any negative reports ever filed by your instructors?	Yes	No	☐
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	Yes	No	☐

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.***
(Use the *Addendum to Question #23 Form* if additional space is needed)

(If NO please skip to question # 33) ☑ Yes ☐ No

Postgraduate Training ☒

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)		
Santa Rosa Family Medicine Residency	*Santa Rosa, CA*	*Family Medicine*	Start	*07/01/2012*	☐
			End	*06/30/2014*	
			Start		☐
			End		
			Start		☐
			End		
			Start		☐
			End		

APPLICANT: *Anna L. Chollet*
(Print Name)

DATE OF BIRTH: [redacted]
(mm/dd/yyyy)

L1B

A "yes" response to questions 18-22 requires a signed and dated written explanation.

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING			MBC Use Only
24. Have you ever received partial or no credit for a postgraduate training program?	Yes	No	
25. Have you ever taken a leave of absence or break from your training?	Yes	No	
26. Have you ever been terminated, dismissed or expelled from a program?	Yes	No	
27. Have you ever resigned from a program?	Yes	No	
28. Were you ever placed on probation for any reason?	Yes	No	
29. Were you ever disciplined or placed under investigation?	Yes	No	
30. Were any incident reports ever filed by instructors?	Yes	No	
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	Yes	No	
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	Yes	No	

MEDICAL LICENSE

License

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.*** (Use the *Addendum to Question #33 Form* if additional space is needed)

☐ Yes ☑ No

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)

ABMS CERTIFICATION

ABMS

34. Are you currently certified by a Member Board of the American Board of Medical Specialties?

☐ Yes ☑ No

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	Yes	No
36. Is there any action currently pending against you?	Yes	No

APPLICANT: *Anna L. Chollet*
(Print Name)

DATE OF BIRTH:
(mm/dd/yyyy)

L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

DEA CERTIFICATION

MBC Use Only

			MBC Use Only
37. Are you currently registered with the Drug Enforcement Agency (DEA)?	Yes	No	DEA

DEA Number	State of Issue	Expiration Date (mm/yyyy)

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	Yes	No	
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	Yes	No	

MALPRACTICE HISTORY

Malpractice History

40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	Yes	No	
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	Yes	No	

DISCIPLINARY HISTORY

Disciplinary History

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	Yes	No	
43. Have you ever been denied a license to practice medicine?	Yes	No	
44. Is any denial pending against you?	Yes	No	
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	Yes	No	
46. Is any disciplinary action pending against any of your licenses to practice medicine?	Yes	No	
47. Have you ever surrendered a license to practice medicine?	Yes	No	
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	Yes	No	
49. 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?	Yes	No	
50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	Yes	No	
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	Yes	No	
52. Is any disciplinary action pending against your hospital or staff privileges?	Yes	No	
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	Yes	No	
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	Yes	No	

APPLICANT: *Anna L. Chollet* (Print Name)	DATE OF BIRTH: (mm/dd/yyyy)	L1D

A "yes" response to questions 38-54 requires a signed and dated written explanation.

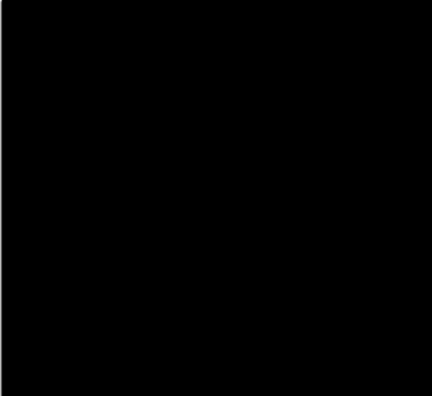
CRIMINAL RECORD HISTORY		MBC Use Only
Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. **For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.**		Criminal History
55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	Yes No	
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	Yes No	
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	Yes No	
58. Are you a registered sex offender?	Yes No	
PRACTICE IMPAIRMENT OR LIMITATIONS		
If you give an affirmative answer to any of the questions below, 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 eligible for licensure. Please note that a Limited Practice License may be available. Please refer to the *Application Information for a Limited Practice License* for further information.		Limitations
59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	Yes No	
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	Yes No	
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	Yes No	
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	Yes No	
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	Yes No	
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	Yes No	

APPLICANT: *Anna L. Chollet* (Print Name) | **DATE OF BIRTH:** (mm/dd/yyyy) | **L1E**

A "yes" response to questions 55-64 requires a signed and dated written explanation.

PHOTOGRAPH

MBC Use Only



Notice: All items in this application 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 licensing 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.

Photograph

DECLARATION

The applicant, *Anna L. Chollet* , [redacted] ,
Please print full name (First, Middle, Last) — Date of Birth (mm/dd/yyyy)

Applicant Name & DOB

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), or 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, alcohol and/or substance 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, 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.

SIGNATURE: [signature] **DATE:** 7/26/13

Applicant Signature & Date

NOTARY SECTION

SIGNATURE OF APPLICANT: [signature]
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

Applicant Signature

State of California

County of Sonoma

Subscribed and sworn to (or affirmed) before me on this 26 day of July, 2013,

Applicant Name & Notary Date

by, Anna L. Chollet proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

[signature: Beth Pardo]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

Notary Signature & Seal

L1F

07A-100 (Rev. 10/2012)

STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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

MBC Use Only

1. NAME: Last: Chollet First: Anna Middle: Louise

Other names you have used (include maiden name):

2. U.S. Social Security Number:

3. Place of Birth:

4. Date of Birth:

5. Gender: ☐ Male ☑ Female

6. Public/Mailing Address: 3569 Round Barn Circle Ste 200
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
Santa Rosa	CA	95403	USA

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

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

9. E-mail Address (optional):

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
Tulane University SOM	New Orleans, LA USA	08/2008-05/2012

L2 Transcript

12. School of Graduation	Degree Awarded	Date of Graduation
Tulane University SOM	M.D.	06-08-2012

Diploma

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
USMLE Step 1	05/2010	
USMLE Step 2 CK	08/2011	
USMLE Step 2 CS	10/2011	

Exams

907.50 0002595 BS
Cashiering Use Only

LA 001
School Code

L1A

07A-100 (Rev. 03/11)

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
Santa Rosa Family Medicine Residency	3569 Round Barn Cir, Santa Rosa, CA 95403	Family Medicine	7-1-12 to current

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

Question		
Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

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: Anna Louise Chollet

DATE OF BIRTH:

L1B

07A-100 (Rev. 12/05)

ABMS CERTIFICATIONS			MBC Use Only
16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☑			ABMS
Member Board	**Expiration Date**	**Certificate Number**	

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? YES NO

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? YES NO

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES NO

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES NO

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES NO

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES NO

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. YES NO

APPLICANT:	**DATE OF BIRTH:**	**L1C**
Anna Louise Chollet		

CRIMINAL RECORD HISTORY (cont'd)

			MBC Use Only Criminal Record
24. Is any criminal action pending against you?	YES	NO	☐
25. Are you required to register as a Sex Offender?	YES	NO	☐

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?	YES	NO	☐
27. Is any denial pending against you?	YES	NO	☐
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?	YES	NO	☐
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES	NO	☐
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?	YES	NO	☐
31. Have you ever had any license to practice medicine subjected to any other disciplinary action?	YES	NO	☐
32. Is any disciplinary action pending against any of your licenses to practice medicine?	YES	NO	☐
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES	NO	☐
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES	NO	☐
35. Is any disciplinary action pending against your hospital staff privileges?	YES	NO	☐
36. Have you ever surrendered a license to practice medicine?	YES	NO	☐
37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES	NO	☐
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?	YES	NO	☐

APPLICANT:	DATE OF BIRTH:	L1D
Anna Louise Chollet		

Notice: All items in this application, except #8 and #9, are mandatory. <u>Failure to provide any of the requested information will delay the processing of your application.</u> 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, Anna Louise Chollet, ________ being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) **(DATE OF BIRTH)**
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. [ALC] **(PLEASE INITIAL BOX)**

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

State of California

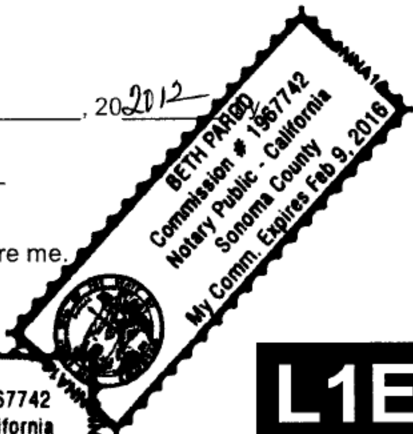
County of Sonoma

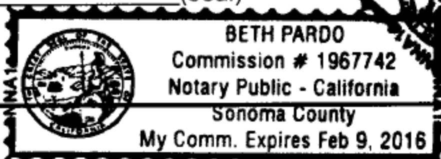
Subscribed and sworn to (or affirmed) before me on this 4 day of Oct, 20 2012

Anna Chollet
(Notary to print name of applicant.)

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

Signature Beth Pardo (seal)





L1E

MHH/SO

STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Anna Louise Chollet ; [redacted]
Full Name of Applicant — U.S. Social Security Number

[redacted] . enrolled in Tulane University School of Medicine
Date of Birth — Name of Medical School

located Louisiana, USA on 08/01/2008
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	Neuroanatomy
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 19th day of May, 2012.
☐ withdrew from medical school on ______ day of __________, ______.

Unusual Circumstances — ***Responses***

	Yes	No
Did this individual ever take a leave of absence from their medical education?	[redacted]	[redacted]
Was this individual ever placed on probation?	[redacted]	[redacted]
Was this individual ever disciplined or under investigation?	[redacted]	[redacted]
Were any incident reports regarding this individual ever filed by instructors?	[redacted]	[redacted]
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	[redacted]	[redacted]

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 Imprinted 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 Jan, 2013.

Printed Name and Title of School Official: Jeffrey G. Wiese, MD
Associate Dean, GME

Signature: [signature]

L2

07A-100-L2 (Rev. 03/11)

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2944 www.mbc.ca.gov

RECEIVED TIME DEC. 21. 12:08PM

MEDICAL BOARD OF CALIFORNIA
Licensing Program

2013 JUL 29

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.

Check one: ☑ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly — APPLICANT INFORMATION			MBC Use Only
NAME: Last *Chollet*	First *Anna*	Middle *Louise*	
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation	Personal Data
[redacted]	[redacted]	*Tulane University SOM*	☑

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form prior to 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 applicant referenced above has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. *The completed form must be mailed directly from the program to the Board.*

				Training Information
Facility Name	Santa Rosa Family Medicine Residency			☑
Facility Address	3569 Round Barn Cir Ste 200 Santa Rosa CA 95403			☑
Specialty	Family Medicine	ACGME 10-digit Program # http://www.acgme.org/adspublic	1200511065	☑ ☑
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2012	End Date (or anticipated completion date):	06/30/2015	☑ ☑

UNUSUAL CIRCUMSTANCES

1. Did the applicant receive partial or no credit for any postgraduate training year?		[redacted]	☐
2. Did the applicant ever take a leave of absence or break from his/her training?		[redacted]	☐
3. Was the applicant ever terminated, dismissed or expelled?		[redacted]	☐
4. Did the applicant ever resign?		[redacted]	☐
5. Was the applicant ever placed on probation?		[redacted]	☐
6. Was the applicant ever disciplined or placed under investigation?		[redacted]	☐
7. Were any incident reports regarding this applicant ever filed by instructors?		[redacted]	☐
8. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?		[redacted]	☐
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?		[redacted]	☐

Program Director: **Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

L3A

Chollet

GENERAL MEDICINE TRAINING REQUIREMENT

MBC Use Only

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 had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

General Medicine

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☑ Yes ☐ No

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant 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. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

ok

Jeff Haney, MD

PRINTED NAME OF PROGRAM DIRECTOR **Email Address**

Program Director's Signature & Date

7-26-13

SIGNATURE OF PROGRAM DIRECTOR **DATE** **Phone Number**

(Signature Stamp Is Not Acceptable)

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority 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.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

Program Director's Signature

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, ______________________ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

____
SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

Notary Signature & Seal

Hospital Seal

L3B

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

ATS # 28765

STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA

Licensing Program

2013 JUL 29 AM 10:51

CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: ☑ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly	APPLICANT INFORMATION		MBC Use Only
NAME: Last *Chollet*	First *Anna*	Middle *Louise*	Personal Data ☑
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation	
[redacted]	[redacted]	*Tulane University SOM*	

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	Santa Rosa Family Medicine Residency		
Facility Address	3569 Round Barn Cir Ste 200 Santa Rosa CA 95403		Program Verified ☑
Specialty Area	Family Med	ACGME 10-digit Program # http://www.acgme.org/adspublic 1200511065	
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2012	Anticipated Completion Date: 06/30/2015	

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L4 must be mailed directly from the program to the Board to be acceptable.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

Jeff Haney, MD
PRINT NAME OF PROGRAM DIRECTOR [redacted] **Email Address**

Program Director's Signature & Date ☑

[signature] 7-26-13 [redacted]
SIGNATURE OF PROGRAM DIRECTOR **DATE** **Phone Number**
(Signature Stamp Is Not Acceptable)

ok

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority 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.

Program Director's Signature ☐

NOTE: If a hospital seal is not available, the program director shall also sign in the section below 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, ______________________________ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

HOSPITAL or NOTARY SEAL

____
SIGNATURE OF NOTARY PUBLIC

Notary Signature & Seal ☐

Hospital Seal ☑

L4

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**126930**
File Number:	**126522**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14151459**
Application Date:	**01/14/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**ANNA**
Middle Name:	**LOUISE**
Last Name:	**CHOLLET**
Birthdate:	****/**/******
Gender:	

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?

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?

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.

Family Physician Training Program Voluntary Fee

Voluntary Fee:

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95403 County: SONOMA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Residency**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**None**
Postgraduate Training Years	**3 Years**
Cultural Background	
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No
E-mail:	

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**

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: