Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14728164**
Application Date:	**12/08/2019 (mm/dd/yyyy)**

Application Questions

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**Yes**
Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted]
Have you served or are you currently serving in the military?	
Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?	
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	
Are you requesting expediting of this application to practice in a medically underserved area or population?	

Personal Detail

First Name:	**Selina**
Middle Name:	**Marie**
Last Name:	**Sandoval**
Birthdate:	**/**/****
Gender:	**Female**
SSN/ITIN:	*********

Addresses

License Related Addresses

Address of Record

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

License Attributes Selected

2170

1575835877491

Transaction [redacted]

Previous Application or License

Have you served or are you currently serving in the U.S. Military? [redacted]

Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?

Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied?

Have you previously held a Physician and Surgeon License in California? **No**

Examinations

Are you certified by the Educational Commission for Foreign Medical Graduates? **No**

Examinations 1

Examination: **United States Medical Licensing Examination (USMLE) Step 1**

Date Passed: [redacted]

Examinations 2

Examination: **United States Medical Licensing Examination (USMLE) Step 2CK**

Date Passed: [redacted]

Examinations 3

Examination: **United States Medical Licensing Examination (USMLE) Step 2CS**

Date Passed: [redacted]

Examinations 4

Examination: **United States Medical Licensing Examination (USMLE) Step 3**

Date Passed: [redacted]

Medical Education

Medical School Name: **University of Illinois College of Medicine at Peoria** [redacted]

Mailing Address of the Medical School: **1 Illini Drive
Peoria, IL
61605**

Attendance Start Date: **08/27/2012 (mm/dd/yyyy)**

Attendance End Date: **05/08/2016 (mm/dd/yyyy)**

ILØ11

1575835877491

Were You Awarded a Degree?	**Yes**
Title of Degree Awarded:	**MD - Doctor of Medicine**
Issue Date of Degree:	**05/08/2016 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada?	**Yes**

ACGME or RCPSC Accredited Postgraduate Training Programs

Program Facility Name:	**University of Kansas Medical Center**
City:	**Kansas City**
State/Province:	**Kansas**
Specialty:	**Obstetrics and Gynecology**
Training Start Date:	**07/01/2016 (mm/dd/yyyy)**
Training End Date:	**06/30/2020 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you ever received partial or no credit for a postgraduate training program?	[redacted]
Have you ever taken a leave of absence or break from your training?	
Have you ever been terminated, dismissed or expelled from a program?	
Have you ever been placed on probation for any reason?	
Have you ever been disciplined or placed under investigation?	
Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, 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 License Information

Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?	**Yes**

Medical License(s)

U.S. State, U.S. Territory or Canadian Province:	**Minnesota**

License Number:	**65290**
Practice Start Date:	**04/22/2019 (mm/dd/yyyy)**
Practice End Date:	**05/17/2019 (mm/dd/yyyy)**

ABMS Certification

Are you currently certified by a Member Board of the American board of Medical Specialties?	**No**

Malpractice History

Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?	[redacted]

Disciplinary History

Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	
Have you ever been denied a license to practice medicine or is any denial pending against you?	
Have you ever had any license to practice medicine subjected to any disciplinary action or is any disciplinary action pending against any of your licenses to practice medicine?	
Have you ever surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation?	
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?	
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?	[redacted]
Have you ever resigned from a medical staff in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges?	
Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	

Have you ever had any healing arts license or certificate disciplined by another state or federal territory? [redacted]

Practice Impairment or Limitations ✓

Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely?

Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

Criminal Record History ✓

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? [redacted]

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 conviction that was set aside or later expunged from the record of the court?

Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

Are you a registered Sex Offender?

Family Physician Training Program Voluntary Fee ✓

Would you like to contribute? [redacted]

Attachments ✓

Fees

Application Fee	**$442.00**
Department of Justice (DOJ) Fee	**$32.00**
Federal Bureau of Investigation (FBI) Fee	**$17.00**
50% Initial License Fee	**$391.50**

StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$907.50**

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

Attestation

I attest 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 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.

Signature: Date:

MR 24490.1 12/08

PHOTOGRAPH

[redacted]

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.

MBC Use Only

Rev L1A-F Staff Initials & Date

MM 12/31/19

Photograph ☑

DECLARATION

Applicant Name & DOB ☑

The applicant, Selina Marie Sandoval, [redacted],
PRINT LEGAL NAME (First, Middle, Last, Suffix) DATE OF BIRTH (mm/dd/yyyy)

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.

Applicant Signature & Date ☑

SIGN LEGAL NAME: Selina Marie Sandoval **DATE:** 12/10/19

NOTARY SECTION

Applicant Signature ☑

SIGNATURE OF APPLICANT: Selina Marie Sandoval
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Kansas

County of Wyandotte

Subscribed and sworn to (or affirmed) before me on this 10 day of December, 2019,

by, Selina Sandoval proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

Bethany Grell
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

BETHANY GRELL
Notary Public – State of Kansas
My Appointment Expires 10/27/21

Applicant Name & Notary Date ☑

Notary Signature & Seal ☑

L1F

MEDICAL BOARD OF CALIFORNIA

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Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CERTIFICATE OF MEDICAL EDUCATION

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

Type or Print Legibly — **APPLICANT INFORMATION** — MBC Use Only

LEGAL NAME: Last	First	Middle	Suffix
Sandoval	Selina	Marie	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	University of Illinois

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

NOTE: If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.

1. Name of Medical School	University of Illinois College of Medicine
2. State/Province/Country	Illinois

3. 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).

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

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

4. Did the applicant withdraw or transfer from this medical school?	[redacted]
5. What is the standard duration of the curriculum at this institution?	4 years
6. Date the applicant was enrolled in medical school? (mm/dd/yyyy)	08/21/12
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine (mm/dd/yyyy)	05/08/16

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

8. Did this applicant ever take a leave of absence from his/her medical education?	[redacted] Yes	[redacted] No
9. Was this applicant ever placed on probation?	[redacted] Yes	[redacted] No
10. Was this applicant ever disciplined or placed under investigation?	[redacted] Yes	[redacted] No
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	[redacted] Yes	[redacted] No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Eileen P. Doherty	Asst. Dean for Student Affairs
SIGNATURE OF SCHOOL OFFICIAL	**DATE**
Eileen P. Doherty	12/9/19

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. 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.

MBC Use Only
- Applicant Information ☑
- Medical School Information ☑
- School Code: IL 011
- ☑
- ☑
- Rev. L2 Staff Initials & Date: MM 12/31/19
- ☑
- ☑
- ☑
- ☑
- Unusual Circumstances ☑
- ☑
- ☑
- ☑
- School Seal ☑
- Signature and Date ☑

L2

Note: Completed form must be mailed directly from the medical school to the Board to be acceptable.

MEDICAL BOARD OF CALIFORNIA

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

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

LEGAL NAME: Last	First	Middle	Suffix
Sandoval	Selina	Marie	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	University of Illinois

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	The University of Kansas Medical Center		
Facility Address	3901 Rainbow Blvd, Kansas City, KS		
Specialty	OB/GYN	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	2201911103
Dates of Training (mm/dd/yyyy)	Start Date: 7/1/2016	End Date (or anticipated completion date): 6/30/2020	

UNUSUAL CIRCUMSTANCES

Program Director: **Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

1. Did the applicant receive partial or no credit during his/her postgraduate training?	☐ Yes	☑ No
2. Did the applicant ever take a leave of absence or break from his/her training?	☐ Yes	☑ No
3. Was the applicant ever terminated, dismissed or expelled?	☐ Yes	☑ No
4. Was the applicant ever placed on probation?	☐ Yes	☑ No
5. Was the applicant ever disciplined or placed under investigation?	☐ Yes	☑ No
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes	☑ No
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	☐ Yes	☑ No

GENERAL MEDICINE TRAINING REQUIREMENT

8. Did the applicant 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

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at **least four (4) 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 (4) 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.*

MBC Use Only

Applicant Information ☑

Verified Program Information ☑

☑ ☑ Unusual Circumstance

☑ ☑ ☑ ☑ ☑ ☑ ☑

Gen Med Required ☑

L3A

APPLICANT INFORMATION

LEGAL NAME: Last: Sandoval | First: Selina | Middle: Marie | Suffix:

MBC Use Only

Applicant's Name ☑

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 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 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 OFFICIAL CERTIFICATION

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.

Verified PD Staff Initials & Date: MM 12/31/19

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.

Kelli Krase, MD

PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)

12/9/19

DATE

Program Director's Signature & Date ☑

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: _____

(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

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

Notary Signature & Seal ☐

Hospital Seal ☑

HOSPITAL or NOTARY SEAL

L3B

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

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CURRENT POSTGRADUATE TRAINING ENROLLMENT

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

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Sandoval	Selina	Marie	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	University of Illinois

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	The University of Kansas Medical Center		
Facility Address	3901 Rainbow Blvd, Kansas City, KS 66160		
Specialty	OB/GYN	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	2201911103
Dates of Training (mm/dd/yyyy)	Start Date: 7/1/2016	Anticipated Completion Date:	6/30/2020

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

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.

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.

Kelli Krase, MD
PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

12/9/19
DATE

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: _____
(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

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

MBC Use Only

- Applicant Information ☑
- Verified Program Information ☑
- Verified PD Staff Initials & Date: MM 12/31/19
- Program Director's Signature & Date ☑
- Program Director's Signature ☐
- Notary Signature & Seal ☐
- Hospital Seal ☑

L4

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

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

December 08, 2019

California, Medical Board of
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

Physician:	Selina Marie Sandoval
Date of birth:	[redacted]
Was issued license number:	65290
On:	April 04, 2019
Expiration date is:	November 30, 2019
Status:	Inactive
Issued on the basis of:	USMLE - United States Med Lic Exam
Corrective action:	None
Disciplinary action:	None

This license information was last updated on: 12/6/2019 9:42:47PM

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

Further public records including disciplinary and corrective actions may be available from the Board's website at www.bmp.state.mn.us under professional profile. If other information is needed, please contact the Minnesota Board of Medical Practice at 612-617-2130.

Ruth M. Martinez
Executive Director