Applicant:	Audrey Lance, MD	**Application ID:**	771525
Profession:	320 (Medicine and Surgery)	**Receipted:**	7/9/2021 Add Transaction
Method:	COMPACT	**Entered:**	7/9/2021
Method From:	Michigan	**Dept Received:**	6/30/2021
Credential Initial:	MD	**Status:**	Permanent license issued
		License #:	1390-320

Check Fee Reduction Eligibility

Save **All Tabs Completed:** ☐

Print Folder Label | Print Mailing Label | Print Checklist | | Email Applicant | Email Letter of Notice | | | | |

Enter Checklist

Requirement	Status	Met Date	Comments	Exam
Application Complete	Met	07/09/2021		
Application fee	Met	07/09/2021	met via compact	
USMLE (Step 1, Step 2, Step 3)	Not Applica			EXAM
National Board Scores, original certification	Not Applica			
FLEX scores, original certification	Not Applica			

Current Address

ADDRESS DIVISION: CREDENTIALING
ADDRESS TYPE: MAILING

AUDREY LANCE
[redacted]
ROYAL OAK MI 48073
UNITED STATES

Applications

Add New Application

Profession	Application ID	Method	Specialty	Sub Profession	Kind
320 (Medicine and Surgery)	771525	COMPACT			

Total Applications : 1

Credentials

Credential Number	Granted	Renewal By	Status
1390-320	07/09/2021	10/31/2023	ACTIVE

Total Credentials : 1

Orders (ICE)

No orders found.

Intake Cases (ICE)

No cases found.

Requirements

Add Requirement | Confirm Requirements

Code	Complied	Complied Date	Printed	Comments	Actions
FEE	Met	10/11/2021		added by CRP 10/11/2021 15:49	
SIG	Met	10/11/2021		10/11/21 APPROVED PER COMPACT-SSadde	

License Type: REGULAR

Status: ACTIVE

Specialty Code: (12) OBSTETRICS AND GYNECOLOGY

Working State: --Select--

Residency: --Select--

Show SSN

View/Edit Continuing Education --Select One--

Renew Disabled: ☐

Notify DOE: ☐ Opt. Out: ☐

Multi State: ☐ Expert: ☐

Exempt Fee: ☐ Military: ☐

Firearm Rnwl Disabled: ☐

Name: Lance, Audrey MD

Renewal Due: 10/31/2023

Profession: Medicine and Surgery

Credential #: 1390-320

Add History | View Online Activity

History

Date	History Type	History	Actions
03/03/2022	LicenseOnHold	Noncompliant with the IPFCF Fund-SS - updated by ACCOUNTS\sandssxghs	
10/11/2021	RenewedAuto	Cred Holder Renewed - Auto Event	
10/11/2021	E-CredConfirmationEmailed	E-Credential renewal notification email sent	
07/09/2021	EndorsedFrom	Endorsed from Michigan	
07/09/2021	LicenseGranted	License granted.	
07/09/2021	FromApplicationMethodInformation	Application 771525 by method COMPACT	
05/20/2007	GraduatedFrom	Graduated from George Washington University School of Medicine	

Renewal Requirements List

Code	Renewal Year	Complied	Complied Date	Printed	Printed Date	Insert Date	Comments
SIG	2021	Met	10/11/2021	No		10/11/2021	10/11/21 APPROVED PER COMPACT-SSadded by CRP SR 10/11/2021 15:49
FEE	2021	Met	10/11/2021	No		10/11/2021	added by CRP 10/11/2021 15:49

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Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL **MICHIGAN BOARD OF MEDICINE** License # **4301089906**

AND at least one of the below must APPLY (Please select all that apply)

a. Your primary residence is in the SPL (State of Principal License) Yes
b. At least 25% of your practice of medicine occurs in the SPL Yes
c. Your employer is located in the SPL Yes
d. You use the SPL as your state of residence for U.S. federal income tax purposes Yes

Please provide below information:

Residence Street address [redacted]

Residence City State Zip **Royal Oak**, **MICHIGAN**, **48073** **USA**

Please describe your practice and location in the SPL selected **I am primarily employed as a gynecologist at Northland Family Planning which has three locations in Southeast Michigan - Southfield, Sterling Heights, and Westland, MI. I do telemedicine in other states through Maven Clinic and Simple Health, however about 75% of my practice is physically in Michigan.**

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer **Northland Family Planning** Employer Contact Phone **(248) 559 - 0590**

Employer Street address **24450 Evergreen Rd Suite 220**

Employer City State Zip **Southfield**, **MICHIGAN**, **48075**

Please provide your Tax ID # (SS#, EIN) [redacted] (must be most recent return)Please be prepared to provide documentation to the designated SPL for further verification.

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Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes

Medical School **George Washington University School of Medicine** Date of Degree Issued **5/20/2007**
Medical Degree Received: M.D.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? Yes

Which licensing exam did you pass? **USMLE**

Have you successfully completed graduate medical education approved by the ACGME or the AOA? Yes

Residency Program **University of Michigan Hospital** Completion Date **6/30/2011**

What is the specialty of the program **Obstetrics & Gynecology**

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) Yes

Name of Specialty Board Certification **American Board of Obstetrics & Gynecology (ABOG)**

Lifetime **No** If not lifetime, Expiration Date **12/31/2021**

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? No

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? No

Have you ever had a controlled substance license or permit suspended or revoked by a state or

the United States Drug Enforcement Administration? No

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? No

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PHYSICIAN'S CORE DATA SHEET

(*Must be the physician's accurate information to avoid delay or rejection*)

Full Legal Name Audrey , Ann , Lance , __

Other names used (maiden, birth) ____, __, __

Residential address [redacted] Royal Oak , MICHIGAN , 48073

Office address 24450 Evergreen Rd Suite 220 , Southfield , MICHIGAN , 48075

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone number [redacted]

Physician's office or practice telephone number of public record (248) 559 - 0590

Date of Birth [redacted] Gender: Female

Email address delegated by applicant to receive correspondence [redacted]

Social Security Number: XXX-XX-XXXX

Physician's National Provider Identifier Number [redacted]

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AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, Audrey Ann Lance (full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to MICHIGAN BOARD OF MEDICINE (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

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

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature Audrey Ann Lance

Type Applicant's Name Audrey Ann Lance
Applicant's NPI [redacted]
Date 5/6/2021

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PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
IMLCC Application Fee	$700.00
ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION	$500.00
MINNESOTA BOARD OF MEDICAL PRACTICE	$392.00
UTAH DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING (MD)	$200.00

TOTAL $1,792.00

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions.

Physician's Signature Audrey Lance

Type Name Audrey Lance

Date 6/21/2021

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MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Audrey Ann Lance
First Middle Last

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number [redacted]

Medical Board Name WISCONSIN MEDICAL EXAMINING BOARD

Member Board License Number 1390-320

Date License Issued 7/9/2021
mm/dd/yyyy

Date of Expiration 10/31/2021
mm/dd/yyyy

Member Board Signature Colin Barushok

Name Colin Barushok
Date 7/9/2021