Medical Quality Assurance Commission
Limited License Application Worksheet

Pending Number _____
License Number _____

Name MEMMEL, LISA M Date of Birth 9/9/1970

Date Received 5/28/02 Date Completed _____ Signature _____

$225.00 Fee	X Photo	X Personal Data	X AIDS	X Affidavit	X SSN	Archive File

Chronology Complete [ ] Missing: _____ to _____, _____, _____

[X] Residency [ ] Institution [ ] Fellowship [ ] City/County [ ] Teaching/Research

[ ] FSMB [ ] AMA

Personal Data Questions	Documentation Received

Malpractice Cases

		Original Complaint	Disposition
1			
2			
3			
4			

Medical School School Code 56.96 [X] U.S. [ ] Canadian [X] International

Name MED COLL OF WISCONSIN Year of Degree 2001 [ ] Transcripts [ ] Translations

Examination Type [ ] National Boards [ ] FLEX [ ] USMLE [ ] State Exam [ ] LMCC [ ] Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified

Received	State Licensure	Received	Hospital Privileges

Received	Program/Employment Verification	Received	Program/Employment Verification
✓	UW 6/25/2002		

Approved Susan Anthony-Gragg Signature 6-12-2002 Date

Comments:

BACKGROUND CHECK PROCESSED

JUN 1 2002

Department of Health
Investigation Service Unit

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

FOR OFFICE USE ONLY

ISSUANCE DATE 6/13/02 (6/25/02)

LICENSE # ML 7193

LICENSE # 7193

APPLICATION FOR LIMITED LICENSE TO PRACTICE MEDICINE
APPLICABLE FOR MD'S ONLY

☐ Teaching-Research (2 year limit) ☒ Internship-Residency ☐ Institution
☐ Fellowship (2 Year Limit) ☐ County-City Health Department

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
MEMMEL	USA	M

NAME OF INSTITUTION/HEALTH DEPT/MEDICAL SCHOOL/HOSPITAL

UNIVERSITY OF WASHINGTON - OBSTETRICS AND GYNECOLOGY

ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)

23 LicenseeAddress

SOCIAL SECURITY NUMBER

22 Licensee SSN

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☒ Female ☐ Male	9/9/1970	MILWAUKEE, WI - U.S.A.

Have you previously applied for a Washington State license or limited license? ☐ Yes ☒ No

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5'6"	115
EYE COLOR	**HAIR COLOR**
BLUE	BLONDE

MEDICAL SCHOOL	YEAR OF GRADUATION
MEDICAL COLLEGE OF WISCONSIN	2001

MEDICAL SPECIALITY

OBSTETRICS AND GYNECOLOGY

DOH 657-056 (REV 11/98)

USA M.D.

2. PERSONAL DATA QUESTIONS (continued)

	YES	NO
10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☒
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

3. EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (Mo/Yr)	Diploma or Degree Obtained (Quote titles in original language an translate to English.)
Medical Education (List all Medical Schools Attended)				
MEDICAL COLLEGE OF WISCONSIN	4	8/97	5/01	M.D.
Post-Graduate Training (List all Programs Attended)				

4. PROFESSIONAL EXPERIENCE

In chronological order list all professional experience received since graduation from medical school to the present. (Exclude activities listed under other sections, identify any periods of time break of 30 days or more.) (Attach additional 8 1/2 X 11 sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (Mo/Yr)
VOLUNTEER - HOSPITAL NICARAGUENSE ALEMAN (MANAGUA, NICARAGUA)	7/01	10/01
VOLUNTEER - MEDICAL CLINIC (SAN LUCAS TOLIMAN, GUATEMALA)	3/01	5/01

5. HOSPITAL PRIVILEGES

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES Beginning (mo/yr)	DATES Ending (mo/yr)
—		

2. PERSONAL DATA QUESTIONS

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.		
1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).		
1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.		
(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)		
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.		
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.		
If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.		
5. Have you ever been convicted , entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

6. LICENSES IN OTHER STATES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

State, Country or Province	Date License Issued	License Number	Basis of Licensure		Status of License Active or Inactive	Any Limitations On License
			Examination (Date Passed)	Endorsement		
—						

7. FIFTH PATHWAY (Foreign Trained Applicants only) (Attach additional 8 ½ X 11 sheets if necessary.)

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended	
		Beginning(mo/yr)	Ending (mo/yr)
—			

8. AIDS AFFIDAVIT

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department of Health if requested. (WAC 246-919-380)

Lisa M. Memmel — APPLICANT'S SIGNATURE

5/28/02 — DATE

9. APPLICANT'S ATTESTATION

I, LISA M. MEMMEL, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, of the Uniform Disciplinary Act, and that I have answered all questions in the application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

Lisa M. Memmel — APPLICANT'S SIGNATURE

5/28/02 — DATE

Official Use Only

Washington State Records Center

HPQA
RECEIVED
JUN 03 2002
CSC

097911

SEE BACK FOR RECORD KEY

THE MEDICAL COLLEGE OF WISCONSIN

MEDICAL COLLEGE OF WISCONSIN

ESTABLISHED IN 1913 AS THE MARQUETTE UNIVERSITY SCHOOL OF MEDICINE
8701 WATERTOWN PLANK ROAD • MILWAUKEE, WISCONSIN 53226

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

LAST NAME	FIRST NAME	MIDDLE NAME	SOC. SEC. NO.	DATE OF ENTRANCE
MEMMEL	LISA	MARIE	22 Licensee SSN	August 12, 1997

DATE OF BIRTH	PLACE OF BIRTH	FIRST YEAR DATES OF ATTENDANCE
09/09/70	Milwaukee, WI	8/12/97 to 5/29/98

SECOND YEAR DATES OF ATTENDANCE: 8/24/98 to 5/14/99

SEX	VETERAN	CITIZEN OF U.S.	DATE OF ENTRY	THIRD YEAR DATES OF ATTENDANCE
F	No	Yes		6/28/99 to 6/28/00

FOURTH YEAR DATES OF ATTANDANCE: 7/1/00 to 5/17/01

DEGREE	DATE
Doctor of Medicine	May 19, 2001

RECORD KEY: H - Honors HP - High Pass P - Pass LP - Low Pass F - Fail I - Incomplete EX - Exempt

ACADEMIC YEAR 1997/98

CLINICAL HUMAN ANATOMY	HP
INTEGRATED MEDICAL NEUROSCIENCE	H
CELL AND TISSUE BIOLOGY	HP
HUMAN DEVELOPMENT	HP
BIOCHEMISTRY	HP
PHYSIOLOGY	HP
CLINICAL CONTINUUM PROGRAM	H
Foundations of Human Behavior	-H
Medical Information Management	-HP
Mentor Program	-H

ACADEMIC YEAR 1998/99

MICROBIOLOGY	HP
PATHOLOGY	HP
PHARMACOLOGY	H
FOUNDATIONS OF CLINICAL PSYCHIATRY	H
CLINICAL CONTINUUM PROGRAM	H
Medical Ethics and Palliative Care	HP
Health Policy and Ethics	P
Introduction to Clinical Examination	HP
Mentor Program	H

RECEIVED
JUN 03 2002
Health Professions Section

THIS IS AN EIGHT AND ONE HALF INCH BY ELEVEN INCH DOCUMENT

THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

OFFICIAL TRANSCRIPT ONLY IF REGISTRAR'S SIGNATURE, EMBOSSED SEAL AND DATE ARE AFFIXED.

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225-

Washington State Department of Health

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Memmel, Lisa

LF 0252140000 00335

001467 05/31/2002 22500

(Back of permanent record card)

NAME OF STUDENT MEMMEL, LISA MARIE

THE MEDICAL COLLEGE OF WISCONSIN

HONORS	

ACADEMIC YEAR 1999/00

ANESTHESIOLOGY	H
OPHTHALMOLOGY	P
PSYCHIATRY	H
SURGERY	HP
AMBULATORY MEDICINE	HP
OBSTETRICS/GYNECOLOGY	HP
PEDIATRICS	HP
WARD MEDICINE	P

ACADEMIC YEAR 2000/2001

WARD MEDICINE/PEDIATRICS	HP
MEDICAL SELECTIVE/HEMATOLOGY/ONC.	HP
HEALTH CARE FOR THE HOMELESS	HP
ADOLESCENT MEDICINE	HP
APPRENTICESHIP WITH A MASTER CLINICIAN	H
PLASTIC SURGERY	P
SURGERY/OTOLARYNGOLOGY	H
WOMENS REPRODUCTIVE HEALTH	H
OB/GYN SUB-INTERNSHIP	H

MAY 2 8 2002

Kristy A. Mack
REGISTRAR

Washington State Department of Health
Medical Quality Assurance Commission
1300 SE Quince Street
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Medical Quality Assurance Commission
Residency Certification

This is to certify that Lisa Memmel MD has been

appointed as a resident* in OBgyn (SERVICE) at

the University of Washington Medical Center hospital for the period

beginning June 25, 2002 (MONTH DAY YEAR). The individual responsible for this resident's

patient care activities will be Zane A. Brammer (SIGNATURE) DIRECTOR OF PROGRAM.

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of post graduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

telnet (GothomCity)

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                      AAAAAA     SSSSSS    IIIIIIIIIII
                     AAAAAAA    SSS  SSS   IIIIIIIIIII
MEDICAL BOARD             ASSESSMENT SYSTEMS, INC.                  06-10-02
hab0303                         REAL SYSTEM          V2.5.74        01:29:06 PM
INDIVIDUAL NAME                   (JR,SR,III)       REFERENCE # CA00006556
   LAST MEMMEL                                      SOC SEC NUM [22 Licensee SSN]
  FIRST LISA                              +-ADDITIONAL INFORMATION----------------+
 MIDDLE M                                 |           SEX F =      MARRIED   =    |
                                          |                                       |
RESIDENCE INFORMATION                     |   OTHER NAME                          |
UNIVERSITY OF WASHINGTON                  |CORP. OFFICER                      =   |
SCHOOL OF MEDICINE                        |TRUST ACCOUNT                          |
BOX 356340                                |                                       |
SEATTLE WA 98109                          |  BIRTH PLACE MILWAUKEE WI             |
                                          |         DATE 09-09-1970               |
PHONE: (   )    -      COUNTY:   17       |                                       |
       (   )    -      LGL ST: WA         |SCHOOL CODE 56.06                      |
                                          |   CE UNITS    0.00 REQD BY   -  -     |
NOTES                                     +---------------------------------------+

+-------------------------------------------------------------------------------+
|CURRENT STATUS: U    EXPIRATION DATE:   -  -      FIRST ISSUE DATE:   -  -     |
|RENEWAL STATUS:     LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE:   -  -     |
|COMPLAINTS O/C:  0/ 0      AUTHORITY:                                          |
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