Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14900453**
Application Date:	**06/29/2021 (mm/dd/yyyy)**

Application Questions

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**No**
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?	[redacted]
Do any of the AB 2113 statements apply to you?	

Personal Detail

First Name:	**Carleyna**
Last Name:	**Nunes**
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.**

General Information

Are you a registered sex offender? [redacted]

Previous Application or License

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

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Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied?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: **04/25/2009 (mm/dd/yyyy)**

Examinations 2

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

Date Passed: **10/26/2010 (mm/dd/yyyy)**

Examinations 3

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

Date Passed: **11/02/2010 (mm/dd/yyyy)**

Examinations 4

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

Date Passed: **06/01/2012 (mm/dd/yyyy)**

Medical Education

Medical School Name: **The Warren Alpert Medical School of Brown University**

Mailing Address of the Medical School: **222 Richmond St, Providence, RI 02903**

Attendance Start Date: **08/20/2007 (mm/dd/yyyy)**

Attendance End Date: **05/29/2011 (mm/dd/yyyy)**

Were You Awarded a Degree? **Yes**

Title of Degree Awarded:	**MD - Doctor of Medicine**
Issue Date of Degree:	**05/29/2011 (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 Arizona Medical Center**
City:	**Tucson**
State/Province:	**Arizona**
Specialty:	**Obstetrics and Gynecology**
Training Start Date:	**07/01/2011 (mm/dd/yyyy)**
Training End Date:	**06/20/2015 (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?	[redacted]

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) 1

U.S. State, U.S. Territory or Canadian Province:	**Arizona**
License Number:	**50034**

Practice Start Date:	**09/01/2015 (mm/dd/yyyy)**
Practice End Date:	**10/01/2016 (mm/dd/yyyy)**

Medical License(s) 2

U.S. State, U.S. Territory or Canadian Province:	**Virginia**
License Number:	**0101260851**
Practice Start Date:	**10/01/2016 (mm/dd/yyyy)**
Practice End Date:	**10/01/2019 (mm/dd/yyyy)**

Medical License(s) 3

U.S. State, U.S. Territory or Canadian Province:	**Texas**
License Number:	**s2438**
Practice Start Date:	**10/01/2019 (mm/dd/yyyy)**

ABMS Certification

Are you currently certified by a Member Board of the American board of Medical Specialties?	**Yes**

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?	[redacted]
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?

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?

[redacted]

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**
Initial License Fee	**$783.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$1299.00**

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:

RF 6/[illegible]/21 #2057004

MBC USE ONLY

PHOTOGRAPH AND NOTICE

[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.

Reviewed L1A-L1F

Staff Initials & Date MK 8/4/21

Photo

DECLARATION

Full Legal Name (First, Middle, Last, Suffix) | Date of Birth (mm/dd/yyyy)

The applicant, Carleyna Marian Nunes, [redacted], 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; and 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.

Applicant Name & DOB

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: [signature] **DATE:** 07/02/2021

NOTARY SECTION

Applicant Signature

SIGNATURE OF APPLICANT: [signature]
(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.

Applicant Name & Notary Date

State of Texas County of Montgomery

Subscribed and sworn to (or affirmed) before me on this

2 day of July, 20 21,

Print Applicant's Legal Name

by, Carleyna Marian Nunes

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

[signature]
SIGNATURE OF NOTARY PUBLIC

(NOTARY SEAL)

NOTARY PUBLIC STATE OF TEXAS

ELIZABETH VAN DYKE
Notary Public
STATE OF TEXAS
My Comm. Exp. 02-26-25
Notary ID # 13294578-6

Notary Signature & Seal

Form **L1F**

Medical Board of Calif

Timeline of Activities

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

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Nunes	Carleyna	Mariah	

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

TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide a written chronological description of all your professional and non-professional activities. Include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format.

Location (Facility Name, Address, and Supervisor)	Start Date
Houston Women's Reproductive Services 5225 Katy Freeway Houston, TX 77007 Supervisor: Robert Friedman MD	03/01/2021
Activities	**End Date**
Office Based Family Planning Services	Current

Location (Facility Name, Address, and Supervisor)	Start Date
HCA St. Luke's The Woodlands Hospital 17200 St. Luke's Way Conroe Tx, 77384 Supervisor: Kristi Moss MD	10/01/2019
Activities	**End Date**
OB/Gyn Hospitalist	Current

Location (Facility Name, Address, and Supervisor)	Start Date
Capital Women's Care 6355 Walker Lane Suite 508 Alexandria VA 22310 Supervisor Damon Hou MD	10/01/2016
Activities	**End Date**
Private Group Practice OBGyn	10/01/2019

Location (Facility Name, Address, and Supervisor)	Start Date
La Dea Women's Health / Genesis OBGyn 6261 N. La Cholla Blvd. Tucson, AZ 85741 Supervisor: Chris Sullivan MD	09/01/2015
Activities	**End Date**
Private Group Practice OBGyn	10/01/2016

SIGN LEGAL NAME: [signature] **DATE:** 06/29/2021

Applicant's signature and date are required

Form TOA

Medical Board of Calif

Timeline of Activities

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

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Nunes	Carleyna	Mariah	

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

TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide a written chronological description of all your professional and non-professional activities. Include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format.

Location (Facility Name, Address, and Supervisor)	Start Date
University of Arizona 1501 N. Campbell Avenue Tucson AZ 85719	07/01/2011
Activities	**End Date**
OBGyn Residency – Supervisor Amy Mitchell MD	06/20/2015

Location (Facility Name, Address, and Supervisor)	Start Date
Activities	**End Date**

Location (Facility Name, Address, and Supervisor)	Start Date
Activities	**End Date**

Location (Facility Name, Address, and Supervisor)	Start Date
Activities	**End Date**

SIGN LEGAL NAME: [signature] **DATE:** 06/29/2021

Applicant's signature and date are required

Form TOA

Medical Board of California

Certificate of Medical Education

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

MBC USE ONLY

TYPE OF APPLICATION

(Check One)

☒ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

APPLICANT INFORMATION

Applicant Information

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Nunes	Carleyna Nunes	Marian	

Applicant Information

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

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 mailed directly to the Board from the medical school.

Medical School Information

Name of Medical School: The Warren Alpert Medical School of Brown University

School Code: R1002

State/Province/Country: Rhode Island, U.S.A.

Rev. MED Staff Initials & Date: MK 8/4/21

Did the applicant withdraw or transfer from this medical school? [redacted]

What is the standard duration of the curriculum at this institution? 4 **years**

Date the applicant was enrolled in medical school: (mm/dd/yyyy) 08/20/2007

Date the applicant was issued the diploma of Bachelor/Doctor of Medicine: (mm/dd/yyyy) 05/29/2011

MEDICAL SCHOOL OFFICIAL CERTIFICATION

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.

THE WARREN ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY OFFICIAL SEAL

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.

School Seal

Allan R. Tunkel, MD, PhD, MACP — PRINTED NAME OF SCHOOL OFFICIAL

Senior Associate Dean of Medical Education — TITLE OF SCHOOL OFFICIAL

Signature & Date

Allan R. Tunkel — SIGNATURE OF SCHOOL OFFICIAL

07/01/2021 — DATE

DOCS

JUL 01 2021

Note: The completed form must be submitted directly from the medical school to the Board to be acceptable

Form MED

2057004
NCW
6/29

Medical Board of California

Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training

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

MBC USE ONLY

APPLICANT INFORMATION

Check One: ☒ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Applicant Information ✓

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Nunes	Carlyna	Mariah	

Date Of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Warren Alpert Medical School of Brown University

PROGRAM DIRECTOR TO COMPLETE ACGME, RCPSC, or CFPC TRAINING INFORMATION

Facility Name	University of Arizona	Verified Program Information ✓
Facility Address	1501 N. Campbell, Box 245078 Tucson, AZ 85724	
Specialty	Required: OB/GYN	✓
ACGME 10-digit Program# https://apps.acgme.org/ads/Public	Required: 2200321025	
Dates of Training	Start Date (mm/dd/yyyy): 07/01/2011 — End Date (or anticipated completion date): (mm/dd/yyyy): 06/30/2015	✓ ✓

UNUSUAL CIRCUMSTANCES

Program Director: 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 this form.

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

GENERAL MEDICINE TRAINING REQUIREMENT

Applicants must complete and receive credit for at **least four (4) months** of general medicine as part of their postgraduate training. 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.

8. Did the applicant complete and received credit for a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☒ Yes ☐ No

Gen Med Required ✓

DOCS

JUL 13 2021

Form PTA

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
Nunes	Carleyna	Mariah	

MBC USE ONLY
Applicant 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.

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. The person who signs this form may not be related to the applicant by blood, marriage, or adoption.

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 the applicant 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, RCPSC, or CFPC to offer the type and level of training completed by the applicant named on this form, and the applicant was trained in an ACGME, RCPSC, or CFPC slotted program position.

Verified PD Staff Initials & Date
MK 8/4/21

Amy Mitchell, MD

PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR

06/29/2021

DATE

Program Director's Signature & Date ✓ verified by PC

Note: If a program 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 PRESENCE OF NOTARY)

Program Director's Signature ○

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____,

Print Program Director's Name

by, _____

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

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ✓

SIGNATURE OF NOTARY PUBLIC

DOCS ✓

JUL 13 2021

Note: The completed forms must be submitted directly from the program to the Board to be acceptable.

Form PTB

MK

Arizona Medical Board

General Information

Carleyna M. Nunes
[redacted]

License Number: 50034
License Status: Active
License Date: 02/10/2015
License Renewed: 03/19/2021
Due to Renew By: 05/19/2023
If not Renewed, License Expires: 09/19/2023

Education and Training

Medical School:
Graduation Date:

Area of Interest: Obstetrics & Gynecology

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Board Actions

None

This license information was last updated on: 06/22/2021

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and other administrative processes.

Board actions taken against physicians in the past 24 months are also available in a chronological list.

June 29, 2021

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

www.dhp.virginia.gov
TEL (804) 367-4400
FAX (804) 527-4475

VERIFICATION

Re: **Carleyna Mariah Nunes**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: June 29, 2021

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine**
License:	**0101260851**
Issued On:	**07/15/2016**
Expires:	**05/31/2022 ***
Current Status:	**Current Active**

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4600, option 2.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from the License lookup section on our website (www.dhp.virginia.gov).

** The expiration date of 1956 indicates that there is no recorded date of expiration for this license, and that it expired sometime prior to 1980.*

Sincerely,

Colanthia M. Opher
Deputy Executive Director for Administration
Virginia Board of Medicine

NOTE: The Board of Medicine no longer provides a raised seal on this document.