Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**15077087**
Application Date:	**01/07/2023 (mm/dd/yyyy)**

Application Questions

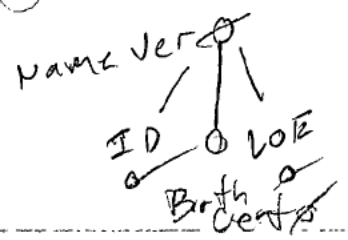
Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**No**
Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted] ϕ — ITIN/SSN verification
Have you served or are you currently serving in the military?	
Are you the spouse or domestic partner of an active duty member of the Armed Forces, holding a current/active license in another state, requesting expediting of this application?	
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?	
Do any of the AB 2113 statements apply to you?	
Are you requesting a temporary license due to being married to, or in a domestic partnership or other legal union with, an active duty member of the U.S. Armed Forces who is assigned to a duty station in California under official active duty military orders?	
Are you requesting expediting of this application as you will be providing abortion services as defined in Section 123464 of the Health and Safety Code?	[redacted]

Personal Detail

First Name:	**Aurelie**

4/17/23

Last Name:	**Cabou**
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

Secondary Status [redacted]

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? [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? [redacted]

Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied?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

Have you previously held a Physician and Surgeon License in California? [redacted]

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	**02/10/2006 (mm/dd/yyyy)**

Examinations 2

Examination	**United States Medical Licensing Examination (USMLE) Step 2CK**
Date Passed	**02/09/2007 (mm/dd/yyyy)**

Examinations 3

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

Date Passed	**11/03/2006 (mm/dd/yyyy)**

Examinations 4

Examination	**United States Medical Licensing Examination (USMLE) Step 3**
Date Passed	**05/06/2009 (mm/dd/yyyy)**

Medical Education

Medical School Name	**Perelman School of Medicine at the University of Pennsylvania**
Mailing Address of the Medical School	**3400 Civic Center Blvd, Philadelphia, PA 19104**
Attendance Start Date	**08/30/2003 (mm/dd/yyyy)**
Attendance End Date	**05/31/2007 (mm/dd/yyyy)**
Were You Awarded a Degree?	**Yes**
Title of Degree Awarded	**MD - Doctor of Medicine**
Issue Date of Degree	**05/14/2007 (mm/dd/yyyy)**

ACGME, RCPSC or CFPC Accredited Postgraduate Training Programs

Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC or CFPC-accredited postgraduate training in Canada?	**No**

ACGME, RCPSC or CFPC Accredited Postgraduate Training Programs Information

Program Facility Name	**Swedish Family Medicine Residency First Hill**
City	**Seattle**
State/Province	**Washington**
Specialty	**Family Medicine**
Training Start Date	**06/30/2007 (mm/dd/yyyy)**
Training End Date	**06/30/2010 (mm/dd/yyyy)**

ACGME, RCPSC, or CFPC 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?	[redacted]
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** FSMB

Medical License(s) 1

U.S. State, U.S. Territory or Canadian Province	**Washington**
License Number	**60094852** * 2135
Practice Start Date	**07/06/2009 (mm/dd/yyyy)** - 1/28/25

Medical License(s) 2

U.S. State, U.S. Territory or Canadian Province	**Alaska**
License Number	**7013**
Practice Start Date	**09/01/2010 (mm/dd/yyyy)**
Practice End Date	**12/31/2014 (mm/dd/yyyy)**

Medical License(s) 3

U.S. State, U.S. Territory or Canadian Province	**Kansas**
License Number	**04-46177**
Practice Start Date	**05/09/2022 (mm/dd/yyyy)**

Medical License(s) 4

U.S. State, U.S. Territory or Canadian Province	**Florida**
License Number	**TPME4927** Live Verify
Practice Start Date	**10/18/2022 (mm/dd/yyyy)**

Medical License(s) 5

U.S. State, U.S. Territory or Canadian Province	**Arizona**
License Number	**68493**
Practice Start Date	**11/14/2022 (mm/dd/yyyy)**

Medical License(s) 6

U.S. State, U.S. Territory or Canadian Province	**Texas**

License Number	Texas U0890
Practice Start Date	12/09/2022 (mm/dd/yyyy)

ABMS Certification

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

Malpractice History Information

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?	[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?

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Attachments

Fees

Application Fee	**$625.00**
Department of Justice (DOJ) Fee	**$32.00**
Federal Bureau of Investigation (FBI) Fee	**$17.00**
Initial License Fee	**$863.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$1562.00**

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:

Medical Board of California

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
Cabou	Aurelie	R	

Date of Birth	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Perelman School of Medicine at the University of Pennsylvania

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
Swedish Family Medicine Residency 1401 Madison St Suite 100, Seattle WA 98104	06/30/2007
Activities	**End Date**
Family medicine residency. Residency director, Michael Tuggy	06/30/2010

Location (Facility Name, Address, and Supervisor)	Start Date
Addiction Medicine Services 5300 Tallman Ave NW, Seattle, WA 98107	08/01/2010
Activities	**End Date**
locums physician position for inpatient detox program. Supervisor, Jim Walsh	08/30/2010

Location (Facility Name, Address, and Supervisor)	Start Date
International Community Health Services, International District Clinic 720 8th Ave S, Seattle, WA 98104	09/01/2010
Activities	**End Date**
locums physician position, outpatient family medicine clinic. Supervisor, Kimo Hirayama	06/25/2011

Location (Facility Name, Address, and Supervisor)	Start Date
Maternity leave	06/26/2011
Activities	**End Date**
	10/30/2011

SIGN LEGAL NAME: [signature] **DATE:** 1/7/2023

Applicant's signature and date are required

Form TOA

Medical Board of California

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
Cabou	Aurelie	R	

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Perelman School of Medicine at the University of Pennsylvania

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
Group Health (Kaiser) 201 16th Ave E, Seattle, WA 98112	10/31/2011
Activities	**End Date**
locums physician in float pool for outpatient family medicine clinic. Supervisor Peter Lightbody	12/31/2012

Location (Facility Name, Address, and Supervisor)	Start Date
International Community Health Services, Holly Park Clinic 3815 S Othello St, Seattle, WA 98118	1/1/2013
Activities	**End Date**
family medicine physician at outpatient family medicine clinic. Supervisor Grace Wang	01/31/2015

Location (Facility Name, Address, and Supervisor)	Start Date
Vera Whole Health 4540 Sand Point Way NE Suite 100	02/01/2015
Activities	**End Date**
family medicine physician at outpatient family medicine clinic, staff physician until 06/2021, locums physician 1/2022 to present	ongoing

Location (Facility Name, Address, and Supervisor)	Start Date
Polyclinic 9709 3rd Ave NE, Seattle, WA 98115	07/14/2021
Activities	**End Date**
family medicine physician at outpatient clinic	10/31/2021

SIGN LEGAL NAME: [signature] **DATE:** 1/7/2023

Applicant's signature and date are required

Form TOA

Medical Board of California

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
Cabou	Aurelie	Rachel	

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Perelman School of Medicine at the University of Pennsylvania

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
98point6 701 5th Ave #2300, Seattle, WA 98104	05/01/2022
Activities	**End Date**
telemedicine physician	ongoing

Location (Facility Name, Address, and Supervisor)	Start Date
Planned Parenthood of the Great Plains 2226 E Central Ave, Wichita, KS 67214	05/01/2022
Activities	**End Date**
Abortion provider at local clinic	ongoing

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:** 3/25/2023

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
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

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

Applicant Information

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
Cabou	Aurelie	Rachel	

Applicant Information

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Perelman School of Medicine at the University of Pennsylvania

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: Perelman School of Medicine at the University of Pennsylvania

School Code: PA 01A

State/Province/Country: Pennsylvania

Rev. MED Staff Initials & Date: BC 3/23

Did the applicant withdraw or transfer from this medical school? ☐ Yes ☑ No

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

Date the applicant was enrolled in medical school: (mm/dd/yyyy) 08/13/2003

Date the applicant was issued the diploma of Bachelor/Doctor of Medicine: (mm/dd/yyyy) 05/14/2007

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Medical School Official: Provide a signed and dated letter of explanation, including dates, for any "Yes" response to questions # 1-4. The explanation must be provided on medical school letterhead and submitted directly to the Board with this form.

1. Did this applicant ever take a leave of absence from their medical education? [redacted]
2. Was this applicant ever placed on probation?
3. Was this applicant ever disciplined or placed under investigation?
4. Were any limitations or special requirements imposed on this applicant because of academic or disciplinary problems, or for any other reasons?

MEDICAL SCHOOL OFFICIAL CERTIFICATION

Attention Medical School: The president, dean, or registrar may sign this form. If the president, dean, or registrar is delegating signature authority to another person, attach evidence of that delegation to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

AFFIX MEDICAL SCHOOL SEAL

DOCS
JAN 12 2023

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

William Pluta	Registrar, Perelman SOM
PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Wil J Pluta	01/09/2023
SIGNATURE OF SCHOOL OFFICIAL	DATE

Signature & Date

Note: The medical school must submit the completed form directly to the Board through the Board's Direct Online Certification Submission (DOCS) portal or by mail to be acceptable.

Form MED

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
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

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

Medical School ✓

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
CABOU	AURELIE	RACHEL	

Applicant Information ✓

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	License # (if applicable)	Medical School of Graduation
[redacted]	[redacted]		Perelman School of Medicine at the University of PA

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

Verified Program Information ✓

Facility Name Required: Swedish Family Medicine Residency – First Hill

Facility Address Required: 1401 Madison St. Suite 100, Seattle, WA 98104

Specialty/ ACGME # ✓

Specialty Required: Family Medicine

ACGME 10-digit Program# https://apps.acgme.org/ads/Public Required: 1205431326

Dates of Training ✓ ✓

Dates of Clinical Training

Start Date (mm/dd/yyyy)	End Date (or anticipated completion date): (mm/dd/yyyy)
06/25/2007	06/24/2010

# of Months ✓

How many months of credit of Board-approved training did the applicant receive at the time this form is signed? Total Number of Months: 36

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 submitted directly to the Board with this form.

1. Did the applicant receive partial or no credit during postgraduate training? ✓
2. Did the applicant ever take a leave of absence or break from training? ✓
3. Was the applicant ever terminated, dismissed, or expelled? ✓
4. Was the applicant ever placed on probation? ✓
5. Was the applicant ever disciplined or placed under investigation? ✓
6. Has the applicant ever had any limitations or special requirements placed upon them for clinical performance, professionalism, medical knowledge, discipline, or for any other reason, which may include, but is not limited to, a corrective action plan, performance improvement plan, remediation plan, individual development plan, and any type of informal or progressive disciplinary or non-disciplinary action? ✓
7. Did the program decline to renew or offer the applicant a postgraduate training program contract for a following year? ✓

GENERAL MEDICINE TRAINING REQUIREMENT

Applicants must complete and receive credit for at least four 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 specialty or sub-specialty area.*

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

Gen Med Required ✓

Form PTA

APPLICANT INFORMATION

MBC USE ONLY

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
CABOU	AURELIE	RACHEL	

Applicant Name ✓

ATTENTION: PROGRAM DIRECTOR

This form may be signed up to 30 days prior to the last day of any postgraduate training period used to qualify the resident for a Physician's and Surgeon's License. Completion of the training program is not required for the program director to complete the form. The form may be signed either: 30 days prior to the resident obtaining credit for the required months of training; or after each year completed; or once the resident's training concludes at the program. For example, if the resident is enrolled in a 36-month program and 12 months of training are needed to qualify the resident for licensure, then the form may be signed after the resident obtains credit for 11 months of training. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility.

The program director or the designated institutional official (DIO) must sign this form. If the program director or the DIO is delegating that signature authority to another person, attach evidence of that delegation 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 or the DIO signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the 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.

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 or DIO Staff Initials & Date

BC 3/23/23

BENJAMIN S. DAVIS, M.D.

PRINTED NAME OF PROGRAM DIRECTOR OR DIO

Program Director or DIO's Signature & Date ✓

SIGNATURE OF PROGRAM DIRECTOR OR DIO
(Signature stamps are not acceptable)

4/03/23

DATE

Note: If a program seal is not available, the program director or the DIO shall also sign in the section below in the presence of a notary public if you are submitting the form by mail.

SIGNATURE OF PROGRAM DIRECTOR or DIO: _____

Program Director's Signature ○

(SIGN FULL NAME IN 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

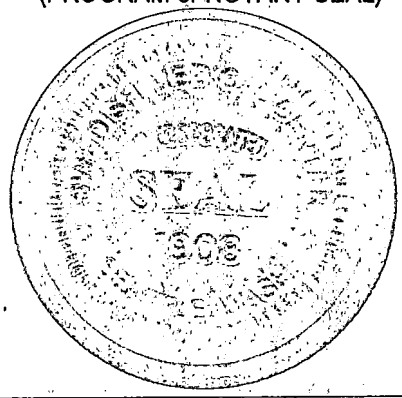
_____ day of _____, 20____,

by, _____

PRINT PROGRAM DIRECTOR OR DIO's NAME

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

(PROGRAM or NOTARY SEAL)



Notary Signature & Seal ○

Program Seal ✓

_____

SIGNATURE OF NOTARY PUBLIC

Note: The program must submit the completed form directly to the Board through the Board's Direct Online Certification Submission (DOCS) portal if the resident has an open application with the Board or by mail to be acceptable.

Form **PTB**

Medical Board of California

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
Cabou	Aurelie	R	

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Perelman School of Medicine at the University of Pennsylvania

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
98point6 701 5th Ave #2300, Seattle, WA 98104	05/01/2022
Activities	**End Date**
telemedicine physician	ongoing

Location (Facility Name, Address, and Supervisor)	Start Date
Planned Parenthood of the Great Plains 2226 E Central Ave, Wichita, KS 67214	05/01/2022
Activities	**End Date**
Abortion provider at local clinic	

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:** 1/7/2023

Applicant's signature and date are required

Form TOA

Application Summary

License Type:	**Physician and Surgeon C**
License Number:	**185638**
File Number:	**2069441**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**15266543**
Application Date:	**01/15/2025 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	[redacted]

Personal Detail

First Name:	**Aurelie**
Middle Name:	**Rachel**
Last Name:	**Cabou**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record

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?	[redacted]
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?	[redacted]
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.	[redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Fees

Biennial Renewal Fee	**$1151.00**
DUE TO CURES FUND	**$18.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$1194.00**

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: