Credential View Screen [update]

Carla Elisse Torres **Address:** · Public ● Mail [change mail address] Carla Elisse Torres 23 LicenseeAddress	ID	1154970	Contact **Audit** Enforcemen Cont. Edu Documents Owned By/I Exams Experience Notes **Schools** Librarian Application **Other State** **Online Info**
	Warnings		
	SSN/FEIN	22 Licensee	
	Contact Standing	Living	
	Contact Type	INDIVIDUAL	
	Birth Date	12/04/1976	
	Public File	YES	
	Mailing List		
	US Citizen		
	Email:	carla.torresmd@gmail.com	

Comments:

Physician And Surgeon License [update] [form letter]

Credential #	**MD.MD.60514581**	**Credential Status**	**PENDING** (10/10/2014)	**Audit** **Documents** Verification **Workflow** Key Mgmt **Fees** **Notes** Print Docs Comp. Audit Renewal **License Statu**
Application Date	10/07/2014	Status Reason	INITIAL APPLICATION IN PROCESS	
Effective Date		**Amount Due**	**$0.00**	
Expiration Date		Date Last Activity	12/1/2014 1:36:37 PM	
First Issuance Date		Last Updated by	Vann, Robert	
Last Date Of Contact	11/27/2014	Certificate Sent Date		
CE Due Date				

RECEIVED
DEC 01 2014
DEPARTMENT OF HEAL
MEDICAL COMMISSIO

Comments:

- **Supervised By**
- **Supervises**
- **User Defined License Data**
- **Workflow**

Supervises [update] [Show All]

No active Supervises Data.

FINGERPRINT
NOV 26 2014
CSO/Credentialing Background

FINGERPRINT
DEC 01 2014
CSO/Credentialing Background

Mihelich, Joe D (DOH)

From: Mihelich, Joe D (DOH)
Sent: Thursday, February 19, 2015 6:47 AM
To: 'carla.torresmd@gmail.com'
Subject: licensed MD.MD.60514581 expires 12/4/15
Attachments: Address change.mht; New Licensee Letter.pdf

You are licensed.

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

Joe Mihelich
Health Services Consultant 1
Medical Quality Assurance Commission
PO BOX 47866
Olympia WA 98504
360-236-2767 phone
360-236-2795 Fax
Website: www.doh.wa.gov/Medical
Email: joe.mihelich@doh.wa.gov

Medical Quality Assurance Commission
Physician Application Worksheet

Name: TORRES, CARLA | DOB: 12/4/1976

Date Received: 10/7/14 | Temp Issued: | Number: 60514581 | Closed:

X	WSP Check	X	Fee	X	Photo	X	Data1-15	X	AIDS	X	Attes	X	SSN

Chronology

Complete	MISSING
X	

FSMB	AMA	ECFMG	FBI
10/9/14	10/9/14	N/A	12/1

Personal Data "Yes"s	Documentation Received

Malpractice Cases

		Synopsis	Disposition
1	Feb-03	x	x
2			
3			
4			
5			
6			
7			

Medical School

Name: UNIV OF TX HOUSTON | Year of Degree: 2002 | 2/4/15 Transcripts | Translations

Examination Type: National | FLEX | USMLE | State Exam | LMCC | 2/9/15 Scores Received

Post Graduate Training Programs

Received	
2/10/15	KEESLER MEDICAL 6/02-6/03
2/7/15	NAVAL SAN DIEGO 6/03-7/06

Post Graduate Training Programs

Received	

Received	State
10/20/14	MS

Received	Hospital verification
2/5/15	MIKE O'CALLAGHAN
2/5/15	DAVID GRANT

Received	Hospital verification

Approved: Signature | Date: 2/18/15

Comments: Dr. Heyer approved

MEDICAL QUALITY ASSURANCE COMMISSION

STAFF MEDICAL CONSULTANT REVIEW

APPLICANT CARLA TORRES **DATE REVIEWED** 2/18/15

SUBMITTED BY: Dawn Thompson

MEDICAL CONSULTANT,

PLEASE REVIEW THE MALPRACTICE INFORMATION IN THE ATTACHED APPLICATION FILE.

APPROVED: ✓ **DISAPPROVED:** _____ **DATE:** 2/18/15

SIGNATURE: [signature]

COMMENTS: _____

541

PHYSICIAN & SURGEON

LOG

Health

REVENUE SECTION

PRINT NAME Torres, Carla

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

"1891"

$541.00

1891-10/7/2014 7:42:56 AM-602

Washington State Department of Health

Background Check Processed
OCT 14 2014
NPDB/HIPDB
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

RECEIVED
OCT 07 2014
DEPARTMENT OF HEALTH
MEDICAL COMMISSION
LOG

Revenue 0252090000

Medical Practice License Application for MDs only

☐ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)

☐ Flex Examination ☒ USMLE Examination

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions) 22 Licensee SSN

☐ Male ☒ Female

Name First	Middle	Last
Carla	Elisse	Torres

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country
12/04/1976	Honolulu	HI	USA

Address: 23 LicenseeAddress

City	State	Zip Code	County
23 LicenseeAddress	23 LicenseeAdd	23 LicenseeAddress	23 LicenseeAddress

Country: USA

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
23 LicenseeAddress	N/A	23 LicenseeAddress

Email address: carla.torresmd@gmail.com

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☒ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☒ No
If yes, list name(s):

Medical Specialty

Medical school University of TX @ Houston Health Science Year of graduation 2002

Medical specialty Obstetrics & Gynecology

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 attach explanation. ☐ ☒

"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, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☒

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☒

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☒

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☒

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☒

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding 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?	☐	☒
b. Diverted controlled substances or legend drugs?	☐	☒
c. Violated any drug law?	☐	☒
d. Prescribed controlled substances for yourself?	☐	☒
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", please attach an explanation 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?	☐	☒
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☒
10. 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?	☐	☒
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☒
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☒

3. Medical Education and Experience

Provide a date listing of your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start mm/yyyy	End mm/yyyy
Medical education (list all medical schools attended)				
University of Tx at Houston Health Science Center	MD	4	07/1998	06/2002
Post graduate training (list all programs attended)				
Keesler Medical Center Biloxi, MS	Internship	1	06/2002	06/2003
Naval Medical Center San Diego, CA	Residency	3	06/2003	07/2006

4. Professional Experience

In date 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. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy	To (mm/dd/yyyy	Nature of experience or specialty
Mike O'Callaghan Federal Hospital Las Vegas, NV	07/01/2006	06/01/2011	OB-Gyn Staff Physician
David Grant Med Cntr Travis AFB, CA	06/15/2011	Present	OB-Gyn Staff Physician

5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy
Mike O'Callaghan Federal Hospital Nellis AFB, NV	07/01/2006	06/01/2011
David Grant Medical Center Travis AFB, CA	06/15/2011	Present

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in date order, starting with the most current.

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
MS	6/2003	18736	6/2003		Active	☒ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials	Date
CT	9/3/14

8. Applicant's Photograph

Photo Here

Height 5'3"

Weight 132

Hair color Brown

Color of eyes Brown

Signature _____

Date of Photo 4/2014

9. Applicant's Attestation

I, Carla Toeros , declare under penalty of perjury under the
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 09/03/2014 at Napa, CA
(mm/dd/yyyy) (city, state)

By: _____
(Signature of applicant)

Washington State Department of Health

MD

Professional Liability Action History

Applicant's name: Carla Toomos Today's date: 9/3/14

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

See attached official case abstract
Involved as ob-gyn intern
Air Force Surgeon general reviewed - Standard of Care met

Date of occurrence: 02/18/2003 Details:

See attached allegation
TOTAL CLAIM $10,000,000.00
ADMINISTRATIVE SETTLEMENT $20,000.00

2. Date suit or claim was filed: 05/28/2004

Name and address of insurance carrier that handled the claim:

AIR FORCE CLAIMS SERVICE

3. Your status in the legal action (primary defendant, codefendant, other): CODEFENDANT
4. Current status of suit or other action: ADMINISTRATIVELY SETTLED
5. Date of settlement, judgment, or dismissal: 2/22/2008
6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount. $20k

You must enclose a copy of final disposition of case this includes dismissals. $ 20,000

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature [signature] Date 9/3/14

CASE ABSTRACT FOR MALPRACTICE CLAIMS
DATE OF REPORT: 09/29/2008

PRIMARY ACT OR OMISSION
START DATE: 02/18/2003
END DATE: 10/27/2003

I. OVERVIEW:
- A. ALLEGATION: The claimant alleged the fetus died in utero as a result of negligent placement and follow-up after placement of a copper T-380 intra-uterine device.
- B. MTF REMARKS:
- C. OTSG REMARKS: 1. A better system for triaging telephone consults at Keesler Medical Center is warranted. The increasing use of e-mail for all types of work increases the chances that an e-mail will be missed (or in this case not received) resulting in inadequate patient follow-up. A confirmation response to the physician/provider is necessary. 2. An X-ray should be requested before IUD expulsion can be confirmed. While the lack of an X-ray did not change the clinical outcome in this case, it should have been discussed with the patient and performed at a time in the pregnancy where the physicians and the patient were comfortable with the small dose of radiation.

II. LOCATION:
- A. INCIDENT UNIT: 0081 MEDICAL GROUP @
- B. DMIS CODE: 0073
- C. CARE LOCATION: Ambulatory
- D. CLINICAL SERVICE CODES:
  1. BCB - GYNECOLOGY CLINIC (Primary)
  2. BIA - EMERGENCY MEDICAL CLINIC (Secondary)

III. PATIENT(S)
- A. NAME: Oswald, Michelle L
  1. GENDER: Female
  2. AGE: 22 Years
  3. PATIENT SSN:
  4. SPONSOR SSN: 145-70-4396
  5. FMP: 1st Spouse
  6. STATUS: Family Member of Active Duty
  7. INJURY SEVERITY: Some
  8. INJURY DURATION: Indeterminate

IV. CLAIMANT(S)
- A. NAME: Oswald, Michelle
  1. CLAIM NUMBER: Keesler AFB 04-349
  2. AMOUNT CLAIMED: $10,000,000.00
  3. CLAIM OUTCOME: Administratively Settled
  4. AMOUNT PAID: $20,000.00
  5. NOTES:

V. PROVIDER
- A. NAME: CAPT TORRES, CARLA, E
  1. STATUS CODE: F11 - Air Force (USAF)
  2. SSN: 22 Licensee SSN
  3. DATE OF BIRTH: 12/04/1976
  4. NAME OF PROFESSIONAL SCHOOL ATTENDED: THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON
  5. DATE GRADUATED: 06/01/2002
  6. SOURCE OF ACCESSION: Health Professional Scholarship Program
  7. LICENSING INFORMATION:

FIELD OF LICENSURE: 010 - Allopathic Physician

STATE OF LICENSE: MS
LICENSE NUMBER: 18736

STATE OF LICENSE: TX
LICENSE NUMBER: K7642

8. SPECIALTY: Obstetrics & Gynecology
9. SUB-SPECIALTY: No Subspecialty
10. LEVEL: In Training
11. NPDB REPORTED:
12. PROVIDER ASSESSMENTS:
    a. TYPE: Civilian
        i. EVALUATION OF CARE: Met
        ii. ASSESSMENT: SOC met.
    b. TYPE: MTF/DTF
        i. EVALUATION OF CARE: Met
        ii. ASSESSMENT:
    c. TYPE: Medical Legal
        i. EVALUATION OF CARE: Not Met
        ii. ASSESSMENT: Standard of care was not met for failure to follow-up on the missing IUD and failure to perform further testing to determine the IUDs location.
    d. TYPE: OTSG
        i. EVALUATION OF CARE: Met
        ii. ASSESSMENT: The AF/SG final SOC determination was SOC met.
        // SIGNED //
        Cheryl W. Sbrockey, MS, RN, CPUR, Contractor
        AFMOA/SG3OQ
        110 Luke Avenue, Rm 405
        Bolling AFB, DC 20032-7050
    e. TYPE: Other
        i. EVALUATION OF CARE: Met
        ii. ASSESSMENT: SOC met.
    f. TYPE: Panel
        i. EVALUATION OF CARE: Met
        ii. ASSESSMENT: SOC met.
13. DPDB INFORMATION:
    DPDB REPORTED:
    DPDB REPORT DATE:
    DPDB SENDER:

VI. CLAIM ASSESSMENTS

A. TYPE: Civilian
    1. ATTRIBUTION OF CAUSE:
    2. EVALUATION OF CARE: Met
    3. ASSESSMENT: SOC met.

B. TYPE: MTF/DTF
    1. ATTRIBUTION OF CAUSE:
    2. EVALUATION OF CARE: Met
    3. ASSESSMENT:

C. TYPE: Medical Legal
    1. ATTRIBUTION OF CAUSE: Personnel
    2. EVALUATION OF CARE: Not Met
    3. ASSESSMENT: Standard of care was not met for failure to follow-up on the missing IUD and failure to perform further testing to

determine the IUDs location.

D. TYPE: OTSG
1. ATTRIBUTION OF CAUSE: System, Personnel
2. EVALUATION OF CARE: Met
3. ASSESSMENT: SOC met.

E. TYPE: Other
1. ATTRIBUTION OF CAUSE: System, Personnel
2. EVALUATION OF CARE: Met
3. ASSESSMENT: SOC met.

F. TYPE: Panel
1. ATTRIBUTION OF CAUSE: System, Personnel
2. EVALUATION OF CARE: Met
3. ASSESSMENT: SOC met.

VII. DIAGNOSES
A. 632 - MISSED ABORTION (1)

VIII. PROCEDURES
A. 69.7 - INSRT INTRAUTERINE CONTRACEPTIVE DEVICE (1)
B. 69.0 - D&C UTERUS (2)
C. 69.59 - OTH ASPIR CURET UTERUS (3)

IX. ATTRIBUTION
A. ACT OR OMISSION CODE(S)
1. 650 - Improper management of course of treatment (02/18/2003 - 10/27/2003) PRIMARY

X. LEGAL
A. DATE CLAIM FILED: 05/28/2004
B. TOTAL AMOUNT CLAIMED: $10,000,000.00
C. ADMINISTRATIVE:
1. ADJUDICATIVE BODY CASE NUMBER: Keesler AFB 04-349
2. ADJUDICATIVE BODY NAME: Air Force Claims Service
3. ADJUDICATIVE DATE OF PAYMENT: 02/22/2008
4. ADJUDICATIVE OUTCOME: 110 - Administratively Settled
5. ADJUDICATIVE DATE OF SETTLEMENT: 02/22/2008
6. ADJUDICATIVE AMOUNT PAID: $20,000.00

XI. OTSG
A. FINAL ASSESSMENT:Met
B. FINAL ACT OR OMISSION CODE(S):
1. 650 - Improper management of course of treatment (02/18/2003 - 10/27/2003) PRIMARY

C. FINAL CLINICAL SERVICE CODE(S):
1. BCB - GYNECOLOGY CLINIC (Primary)
1. BIA - EMERGENCY MEDICAL CLINIC (Secondary)

The University of Texas Health Science Center at Houston
P.O. Box 20036, Houston, Texas 77225

February 10, 2015

Name: Carla Torres

Student ID: 1467771
SSN: 22 Licensee
Birthdate: 12/04/1976

Degrees Awarded

Degree: Doctor of Medicine

Confer Date: 2002-06-01

Beginning of Academic Record

Medical Year 1998-1999

Course Number		Description	Attempted	Grade
BSCI	1001	Biochemistry	0.000	P
BSCI	1002	Gross Anatomy	0.000	P
BSCI	1003	Developmental Anatomy	0.000	P
BSCI	1004	Histology & Cell Biology	0.000	P
Course Topic:		Histology		
BSCI	1005	Microbiology	0.000	P
BSCI	1006	Neuroscience	0.000	P
BSCI	1007	Physiology	0.000	P
BSCI	1010	Immunology	0.000	P
BSCI	1011	Intro Clinical Medicine	0.000	P

Medical Year 1999-2000

Course Number		Description	Attempted	Grade
BSCI	2001	Behavioral Sciences	0.000	P
BSCI	2004	Pathology	0.000	P
BSCI	2005	Pharmacology	0.000	P
BSCI	2007	Genetics	0.000	P
BSCI	2008	Physical Diagnosis	0.000	HP
BSCI	2009	Fundamental Clin Medicine	0.000	P
BSCI	2025	Reproductive Biology	0.000	P
TSKI	2001	Tech Skills (Pass/Fail)	0.000	P

Medical Year 2000-2001

Course Number		Description	Attempted	Grade
FAPR	3001	Family Practice	0.000	H
INTM	3001	Medicine	0.000	P
OBGY	3001	Obstetrics/Gynecology	0.000	HP
PED	3001	Pediatrics	0.000	HP
PSYC	3001	Psychiatry	0.000	H
RAD	3001	Radiology (P,F Only)	0.000	P
SURG	3001	Surgery	0.000	P

Medical Year 2001-2002

Course Number		Description	Attempted	Grade
ANES	4003	Critical Care Medicine	0.000	HP
AWAA	4001	Elective MS Hospital	0.000	H
AWAA	4001	Elective MS Hospital	0.000	H
AWAA	4001	Elective MS Hospital	0.000	HP
FAPR	4000	Required Family Practice	0.000	HP
INTM	4000	Required Ambulatory Med	0.000	H
Course Topic:		Required Medicine		
INTM	4005	Endocrin Clin Elective	0.000	HP
JURI	4001	Med Jurisprudence	0.000	P
NEUR	4000	Required Neurology	0.000	P
OBGY	4026	Ob & Gyn/LBJ Hosp-Yelo Tm	0.000	HP
TSKI	4001	Tech Skills (Pass/Fail)	0.000	P

Professional Medicine Career Totals
Cum GPA: 0.000 Cum Totals 0.000

End of Official

In accordance with the Family Educational Rights and Privacy Act of 1974, this information is being released on the condition that you will not permit any other party to have access to this transcript without written consent of the student.

This official university transcript is printed on secured paper and does not require a raised seal.

Robert L. Jenkins

Robert L. Jenkins, Registrar

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

The University of Texas Health Science Center at Houston is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools. Individual schools and programs are accredited by appropriate professional organizations. Information about accreditation is listed in the General Information section of the Health Science Center catalogs.

The UTHSC-H converted from quarter credit hours to semester credit hours effective Fall, 1987.

Special information is listed below by academic school. Courses taken through an inter-institutional agreement with an affiliated university carry the designation "T" or the university name at the end of the course title.

School of Biomedical Informatics

Prior Names:

School of Health Information Sciences (October 2000 - April 2010)
School of Allied Health Sciences

Grades: A, B, C, D, F; P = Pass; I = Incomplete; AD = Audit; WP = Withdrew Passing; WF = Withdrew Failing.

School of Dentistry

Name changed from Dental Branch to School of Dentistry in June of 2011.

DDS Program

Prior to 1990-1991, a DDS transcript will show, each year, a ranking within a class. Beginning 1990-1991, the transcript will show the rank at the time of graduation. An alphabetical grading system was used until 1985, when the grading system was changed to a numeric grading system from 0-100. Equivalent numerical grading, letter grades and performance are listed below:

Numerical Grade	Letter Grade	Performance
94-100	A	Exceptional
85-93	B	Above Average
76-84	C	Average
70-75	D	Below Average
0-69	F	Failing

In certain courses P (Pass), I (Incomplete), IS (Incomplete Satisfactory), IU (Incomplete Unsatisfactory), and W (Withdrew) are acceptable grades.

Dental Assisting, Dental Hygiene and Dental Postgraduate Programs:

Grades: A, B, C, D, F; P-Pass; I = Incomplete; IS - Incomplete Satisfactory; IU = Incomplete Unsatisfactory; W = Withdrew; WP = Withdrew Passing; WF = Withdrew Failing.

Graduate School of Biomedical Sciences

Prior to Spring, 1982, 3 credit hours of thesis or dissertation were considered a full-time load.

Grades: A, B, C, F; P = Pass; X = In Progress; I = Incomplete; AD = Audit; W = Withdrew; WP = Withdrew Passing; WF = Withdrew Failing.

Medical School

MD Program

Grades: H = Honors; HP = High Pass; P = Pass; MP = Marginal Performance; F = Fail; IH = Incomplete changed to Honors; IP = Incomplete changed to Pass; IF = Incomplete changed to Fail; X = In Progress; NC = No Credit; CR = Credit; W = Withdrew; FP = Fail changed to Pass, I = Incomplete.

HP and MP grades are effective with the Fall, 1985 entering class. Credit hours are not assigned to Medical School courses.

Clinical Research Programs:

Grades: AD = Audit, F = Fail; I = Incomplete; P = Pass; WP = Withdrew Passing; WF = Withdrew Failing;

School of Nursing

Prior to Fall, 1979, credit hours were awarded in semester units.

CBE = Credit by Exam
ADVP = Advanced Placement Credit

Grades: A, B, C, D, F; P = Pass; I = Incomplete; CR = Credit; NC = No Credit; W = Withdrew; WP = Withdrew Passing; WF = Withdrew Failing; AD = Audit; X = In Progress.

School of Public Health

Transcripts that show course credit are produced from microfiche. Each course credit is a graduate level course equivalent to three quarter hours. Transcripts that show credit hours are reported as quarter or semester hours.

Grades: A, B, C, F; P = Pass; F = Fail, I = Incomplete; W = Withdrew

Letter grades (A,B,C,F) are effective Fall 2002.

UTHealth
The University of Texas
Health Science Center at Houston

Office of the Registrar
P. O. Box 20036
Houston, Texas 77225

OFFICIAL TRANSCRIPT

The University of Texas
Health Science Center at Houston

Official Document
Invalid if Seal is Broken

US·MLE
United States
Medical
Licensing
Examination

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Date : 02/09/2015

Recipient:

Washington Medical Quality Assurance Commission
ATTN: MD Credentialing Unit
PO Box 47866
Olympia, WA 98504-7866

Examinee: Torres, Carla E
Alt Name(s): Torres, Carla Elisse

Examinee ID#: 5-081-297-3
Date of Birth: 12/04/1976

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/13/2000	Pass	196	(179)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	10/05/2001	Pass	205	(174)	

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
TEXAS	09/18/2003	Pass	205	(182)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
A-L 360-236-2765
M-Z 360-236-2767

MD

To: Post Graduate Training Program Director

Facility name Keesler Medical Center

Address 301 Fisher St. Biloxi MS 39534

RE: Verification/evaluation of training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Carla Torres	12/04/1976

Signature of applicant: See attached signed auth.

1. Carla E. Torres (Applicant Name (Print or type)) is or was engaged in postgraduate training in our program Keesler Medical Center from Beginning date (month & year) 07/2002 to Ending date (month & year) 09/2005 * in the field of OB/GYN

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☒ Yes ☐ No
If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No
If yes, please explain _____

4. Did this applicant successfully complete this training program? ☒ Yes ☐ No
☐ In process OR ☐ expected date of completion _____

*Transfered to Balboa Navy medical Center to complete residency due to hurricane Katrina.

Return to address listed above.

(SEAL)

Signature _____ MATTHEW B. CARROLL, Col, USAF, MC
Designated Institution Official
Keesler AFB, MS 39534

Title _____

Address 301 Fisher St.
Keesler AFB, MS 39534

Date 10 Feb 2015 Phone (228) 376-3829

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
A-L 360-236-2765
M-Z 360-236-2767

RECEIVED
FEB 18 2015
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

MD

To: Post Graduate Training Program Director

Facility name Naval Medical Center San Diego, CA

Address 34800 Bob Wilson Dr, San Diego, CA 92134

RE: Verification/evaluation of training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Carla Torres	12/04/1976

Signature of applicant

1. Carla Torres (Applicant Name (Print or type)) is or was engaged in postgraduate training in our program Obstetrics & Gynecology Residency

   from Beginning date (month & year) 07/2003 to Ending date (month & year) 6/2006

   in the field of Obstetrics & Gynecology

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☒ Yes ☐ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No

   If yes, please explain

4. Did this applicant successfully complete this training program? ☒ Yes ☐ No
   ☐ *in process* OR ☐ *expected date of completion*

Return to address listed above.

SEAL

Signature

Title Residency Program Director

Address 34800 Bob Wilson Dr.
San Diego, CA 92134

Date 2/4/15 Phone 619-532-5013

DOH 657-034 April 2014

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

VERIFICATION OF MEDICAL LICENSURE

October 20, 2014

This is to certify that the records of the Mississippi State Board of Medical Licensure indicate the following information:

Physician Name: **Carla E Torres** Degree: **M.D.**

Date of Birth: **12/04/1976**

Primary Practice Location: **101 Bodin Circle**
David Grant Medical Center
Travis AFB
Travis AFB, CA 39534

MD/DO School: **University of Texas Medical Sch** Year of Graduation: **2002**

Specialty: **OBSTETRICS AND GYNECOLOGY (Not Primary Source Verified)**

License Number: **18736**

Issue Date: **November 8, 2004** Reinstated Date:

Expiration Date: **June 30, 2015** Date of Expiration Prior to Reinstatement:

Public Record: **NO**

This license information was last updated on: 10/20/2014

If public record is indicated, submit a request for records to the following email address: mboard@msbml.state.ms.us.

Sincerely,

H. Vann Craig M.D.

H. Vann Craig, M.D.
Executive Director

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
A-L 360-236-2765
M-Z 360-236-2767

RECEIVED MD
FEB 05 2015
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

To: Hospital Administration (Excluding post graduate training hospital privileges)

Hospital Name Mike O'Callaghan Federal Hospital

Address 4700 N. Las Vegas Blvd. Nellis AFB, NV 89191

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown above at your earliest convenience. **All questions must be answered.**

Applicant Name (Print or type) Carla Torres

Birth date (mm/dd/yyyy) 12/04/1976

Signature of applicant Signature Auth attached

1. Carla E. Torres MD (DOB 12-4-1976) (Applicant Name (Print or type)) has/had admitting or specialty privileges at this hospital from 7-1-2005 (mm/yyyy) to 5-31-2012 (mm/yyyy).
2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?
   ☐ Yes ☒ No If yes, please explain
3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain
4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☒ No If yes, please explain
5. Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Health Care Integrity and Protection Data Bank by this hospital? ☐ Yes ☒ No

Signature Elizabeth J. Rabbe

Return to address listed above.

E. Rabbe
Verified by
Credentials Specialist, 99 MDG
Nellis AFB NV 89191-6601
Comm: 702-653-3067 DSN: 348-3067

Title Credentials Specialist

Address 4700 Las Vegas Blvd N.
Nellis AFB, Nevada 89191-6601

Date 4 Feb 2015 Phone 702-653-3455

DEPARTMENT OF THE AIR FORCE AND
NELLIS AIR FORCE BASE, NEVADA

4 February 2015

MEMORANDUM TO:
WASHINGTON MEDICAL BOARD
ATTN: Medical Section
111 Israel Rd. SE
Tumwater, WA 98501
360-236-4300 Phone

FROM:
99 MDG/SGHQ/Credentials Office
4700 Las Vegas Blvd North
Nellis AFB, NV 89191-6601

SUBJECT: Privileges Verification Major Carla E. Torres, M.D.

1. Major Carla E. Torres, MD was an active medical staff member, in good standing, of the Mike O'Callaghan Federal Medical Center, Nellis AFB, Nevada 89191-6601. She was fully credentialed and privileged in the specialty of OB/GYN Physician, from 7/1/2005 until 5/31/2012 expiration date with admitting privileges.

2. Dr. Torres's medical liability was covered by the Federal Tort Claims Act at our Federal Facility while she was on staff. To the best of my knowledge there is not any derogatory information, adverse actions, or malpractice claims on file. Aside from this we are unable to provide any additional information.

3. If you have any questions please do not hesitate to contact me at the information listed below.

Respectfully,

Elizabeth I. Rabbe

ELIZABETH I. RABBE, Ctr., USAF
Medical Staff Professional
99 MDG/SGHQ
Nellis AFB, NV 89191-6601
702-653-3455 Phone
702-653-3398 Fax

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
A-L 360-236-2765
M-Z 360-236-2767

RECEIVED
FEB 05 2015
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

MD

To: Hospital Administration (Excluding post graduate training hospital privileges)

Hospital Name David Grant Medical Center Travis AFB, CA

Address 101 Bodin Circle Travis AFB, CA 94535

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown above at your earliest convenience. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Carla Torres	12/04/1976

Signature of applicant

1. Carla Torres (Applicant Name (Print or type)) has/had admitting or specialty privileges at this hospital from 6-7-2011 (mm/yyyy) to Present (mm/yyyy).
2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?
   ☐ Yes ☒ No If yes, please explain
3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain
4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☒ No If yes, please explain
5. Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Health Care Integrity and Protection Data Bank by this hospital? ☐ Yes ☒ No

Signature Monica Bielby, CPCS, CPMSM

Return to address listed above.

Title Credentials Manager

Address 60 MDG/SGHQ

101 Bodin Circle - Travis AFB, CA 94535-1800

Date 4 Feb 15 Phone 707 423-7611

DOH 657-017 April 2014

CompHealth.

VERIFICATION OF HOSPITAL PRIVILEGES / AFFILIATION

2/4/2015

David Grant USAF Medical Center
101 Boden Circle
Travis Air Force Base, CA 94535

To Whom it May Concern:

Carla Torres, is applying for licensure in the state of Washington.
Please complete the following:

1. Enclosed form verifying Privileges/Affiliation held for the time period of 06/2011 to 08/2014.
2. Send to the medical board using the prepaid FedEx air bill I have attached. The board will not accept email or faxed forms.

Washington Medical Board
111 Israel Rd.
Medical Section
Tumwater, WA 98504

I have attached a form signed by the doctor authorizing the release of this information.

Thank you for your assistance. Please let me know if you have any questions.
Sincerely,

Jon Arnell | Licensing Coordinator
CompHealth Locum Tenens
Direct Line: (801) 930-3418
jon.arnell@comphealth.com

PERSONAL DATA
Name: Carla Torres
DOB: 12/4/1976
SS #: 22 Licensee SSN
Dates of Affiliation: 06/2011 to 08/2014

AMA Physician Profile

Name and Mailing Address
CARLA ELISSE TORRES MD
4700 LAS VEGAS BLVD N
NELLIS AFB NV 89191-6600

Primary Office Address
350 K ST
SAN DIEGO CA 92101-6975

Phone 1-619-702-8343

Birth date 12/04/1976

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)

UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1457309726	05/05/2006	NOT RPTD	NOT RPTD	NOT RPTD	10/04/2014

Current and/or historical medical school

UNIV OF TX MED SCH AT HOUSTON, HOUSTON TX 77225
Degree Awarded: Yes
Degree Year: 2002

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: KEESLER MEDICAL CENTER
Sponsoring State: MISSISSIPPI
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/2002 - 06/2005 * (Verified)

**Program reports partial training completed at this institution. Please review final postgraduate training segment(s) to determine completion.*

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
MISSISSIPPI	MD	11/08/2004	06/30/2015	ACTIVE	UNLIMITED	09/17/2014
MISSISSIPPI	MD	10/09/2003	11/30/2003	INACTIVE	RESIDENT	09/17/2014

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
None	Reported			

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	12/31/2013	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	12/16/2012	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	12/31/2011	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	12/31/2010	12/31/2014		RE-CERT	10/03/2014
TIME LIMITED	12/31/2009	12/31/2014		RE-CERT	10/03/2014

AMA AMERICAN MEDICAL ASSOCIATION

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	12/12/2008	12/31/2014		INITIAL	10/03/2014

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Adminstration or the US Public Health Service.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Additional Information

To date, there is no additional information for this physician on file.

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website (www.ama-assn.org/go/amaprofiles) and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Washington Medical Quality Assurance Commission	As of Date:10/9/2014

PRACTITIONER INFORMATION

Name:	Carla Elisse Torres
DOB:	12/4/1976
Medical School:	University of Texas-Houston Medical School Houston, Texas, UNITED STATES
Year of Grad:	2002
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
MISSISSIPPI	18736	11/8/2004	6/30/2015	10/7/2014

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

Mihelich, Joe D (DOH)

From: Mihelich, Joe D (DOH)
Sent: Wednesday, October 22, 2014 4:13 PM
To: 'carla.torresmd@gmail.com'
Subject: missing items Torres

October 22, 2014

Dear Dr. Torres,

This is to acknowledge receipt of your application for your physician and surgeon licensure in the state of Washington.

MISSING ITEM(S)
FBI FINGERPRINT (packet sent)
TRANSCRIPTS
POST GRAD TRAINING VERIFICATION
USMLE SCORES
HOSPITAL VERIFICATION (both)

If you choose to use email as your way of checking on your application, that may be done at any time.

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

If you have any further questions or need additional information, send an email me at joe.mihelich@doh.wa.gov, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Joe Mihelich
Health Services Consultant 1
Medical Quality Assurance Commission
PO BOX 47866
Olympia WA 98504
360-236-2767 phone
360-236-2795 Fax
Website: www.doh.wa.gov/Medical
Email: joe.mihelich@doh.wa.gov

Washington State Department of Health

MOTPTD 60514582 Request Copy

Temporary Permit Request

I hereby request a **one time only temporary permit**. I understand that the temporary permit shall expire upon the issuance of a full license, initiation of an investigation by the commission, or 90 days, whichever occurs first.

Signature: [signature] Date: 9/03/14

Print or type full name: Carla Elisse Torres Date of birth: 12/04/1976

Mailing address: 1336 Cayetano Dr

City: Napa State: CA Zip Code: 94559

Note: Fees submitted with application for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable. See **WAC 246-12-340**.

General Information

Must be licensed in a recognized jurisdiction. See list on page two.

A temporary permit may be issued upon receipt of the following:

1. Completed application form.
   a. If any personal data questions 1-15 have a positive answer, it has to be reviewed by the commission's designee.
2. Temporary permit request form.
3. Application and temporary permit fees paid.
4. A clear Federation of State Medical Boards (FSMB) data bank clearance report.
5. A clear American Medical Association Profile.
6. Written verification from ALL states in which the applicant was or is licensed.

For Office use only

☐ Approved

☐ Disapproved

Review date: _____

Signature: _____

Thompson, Dawn (DOH)

From: Thompson, Dawn (DOH)
Sent: Monday, January 12, 2015 10:12 AM
To: 'carla.torresmd@gmail.com'
Subject: Pending MD license #MD.60514581

January 12, 2015

Dear Dr. Torres,

As of this date, our records indicate the following items still have not yet been received in support of your application for a physician license. In order for us to continue to process your application, we will need the documents listed below.

MISSING ITEMS

Need medical school transcripts
Need USMLE scores
Need all postgraduate training verifications
Need all hospital privilege verifications for the past 5 years

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

Upon receipt of the above items, your application will be considered complete. Depending on the complexity of the application file, the review process may take 3 to 5 working days for routine applications, an additional 14 working days for applications considered non-routine to be reviewed by a Commission Member, or, if your application contains derogatory or disciplinary information, it may need to be reviewed by the Full Commission, which are reviewed at a Commission meeting for final disposition.

If you have any further questions or need additional information, please contact me.

Sincerely,

Dawn Thompson

Dawn Thompson
Licensing Manager
Medical Quality Assurance Commission
PO Box 47866
Olympia WA 98504-7866
360-236-2766
Dawn.thompson@doh.wa.gov

Redaction Date: 8/15/2022 6:54:56 AM

Redaction Log

Total Number of Redactions in Document: 13

Redaction Reasons by Page

Page	Reason	Description	Occurrences
1	23 LicenseeAddress	RCW 42.56.350(2): Health professionals. (2) The current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department are exempt from disclosure under this chapter	1
1	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
7	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
7	23 LicenseeAddress	RCW 42.56.350(2): Health professionals. (2) The current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department are exempt from disclosure under this chapter	7
14	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
17	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
28	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1