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SCAN SHEET
GENERATED 07/17/2008

NAME: HANSON MARILEE ANN

LICENSE ID: MD8555

FULL LIC ID: MD 0008555000

___ MICROFICHE PRESENT

✓ OTHER UNSCANNED ITEMS PRESENT-DESCRIPTION

___ BOUND MATERIAL

✓ PHOTO

___ OTHER

_____

_____

FILE PREP BY: _____ DATE: _____

MD8555 CONTROL#: 5,451-630

RESTORATION

RENEWAL APPLICATION

DEPT. OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
P.O. BOX [redacted] HONOLULU, HI [redacted]

POSTED FEB 6 2002

This form is for the renewal of your license for the next license period, FEB 00 - JAN 02. Instructions & information are on the enclosed sheet. DO NOT USE THIS FORM AFTER JAN 31 02.

BOARD OF MEDICAL EXAMINERS — PHYSICIAN 12/28/01 ckm

LICENSE DATA

LICENSEE'S NAME & ADDRESS OF RECORD:

MARILEE A HANSON
[redacted]

LICENSE NO: MD -
FILE NO: [redacted]

308 00605051	13- 2/08/02	200.00
C13 00605052	13- 2/08/02	90.00

FEES

By LICENSE EXPIRATION DATE JAN 31 00 a TOTAL of $240.00 is due. <---------- *** ON-TIME FEE ***

(AFTER the LICENSE EXPIRATION DATE JAN 31 00 AND BEFORE JAN 31 02, a TOTAL of $290.00 is due. <---------- *** LATE FEE ***

Please make check or money order payable to: COMMERCE AND CONSUMER AFFAIRS (DO NOT MAKE MULTIPLE PAYMENTS)

OTHER REQUIREMENTS

OTHER REQUIREMENTS DUE or SPECIAL INSTRUCTIONS/INFORMATION:

Enclose documentation of continuing medical education. Failure to comply shall result in automatic forfeiture of license subject to restoration upon satisfaction of all appropriate requirements.

If licensed AFTER 12/31/98, no CMEs are required for this renewal.

A license that has been forfeited for one renewal term (two years) shall be automatically terminated and cannot be restored. A new application for licensure will be required.

By signing the renewal application below, you are also certifying that you have complied with the CME requirements as contained in Subchapter 5 of the Board's rules and have attached evidence of CME.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808)586-3000 to submit your request.

INCOMPLETE APPLICATION WILL DELAY PROCESSING

( ) ADDRESS CHANGED? Provide new address

POSTED [redacted]

( ) NAME CHANGED? Check here and submit a copy of the name change document.

RECEIVED PVL LICENSING BRANCH
2002 JAN 31 P 4:10
DEPT OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

TO BE COMPLETED BY LICENSEE

TO BE COMPLETED BY LICENSEE (Circle your answers and provide additional information where requested):

1) In the past 2 years has your license ever been formally disciplined by way of a suspension, restriction, or revocation? ..... Yes (No)
2) Are there any disciplinary actions pending against you? ..... Yes (No)
3) In the past 2 years have you been convicted of a crime? ..... Yes (No)
4) If response is 'Yes' to Question #3, has the conviction been annulled or expunged? ..... Yes (No) N/A

FOR ANY 'YES' RESPONSE ABOVE, PLEASE PROVIDE INFORMATION ON THE DATE, PLACE AND TYPE OF CONVICTION OR DISCIPLINARY ACTION ON A SEPARATE SHEET OF PAPER AND ATTACH TO THIS RENEWAL.

I understand that my license expires on the License Expiration Date shown on this form. I understand that if I fail to renew my license by the license expiration date I am unlicensed and shall not practice. I further understand that I may resume practice only after I have met all appropriate restoration requirements.

SIGNATURE OF LICENSEE M Hanson, MD DATE Jan 30, 2002

HAVE YOU REMEMBERED TO:
1) Attach payment.
2) Answer applicable questions.
3) Sign and date application.
4) If applicable, include required documents.

FOR DCCA ACCOUNTING OFFICE ONLY

TOTAL (ON TIME): $240.00 — REN...308 ::: 150.00 — CRF...C13 ::: 90.00

TOTAL (LATE): $290.00 — REN...308 ::: 200.00 — CRF...C13 ::: 90.00

LICENSE NO:...MD 8555

ON TIME: $240.00

LATE: $290.00

OW
W
2-6-02

DEC - 3 1993

RENEWAL APPLICATION

DEPT. [redacted] OMMERCE & CONSUMER AFFAIRS STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
P.O. BOX 3469, HONOLULU, HI 96801

This form is for the renewal of your license for the next license period, FEB 94 - JAN 96 .
Instructions & information are on the enclosed sheet. DO NOT USE THIS FORM AFTER JAN 31 96 .

BOARD OF MEDICAL EXAMINERS — PHYSICIAN

LICENSE DATA

LICENSEE'S NAME & ADDRESS OF RECORD:
Marilee Ann Hanson
[redacted]

POSTED

Pls. Current address
Marilee Ann Hanson, M.D.
[redacted]

LICENSE NO: MD 8555
FILE NO: [redacted]

FEES

By LICENSE EXPIRATION DATE JAN 31 94 a TOTAL of $240.00 is due. <********** *** ON-TIME FEE ***

AFTER the LICENSE EXPIRATION DATE JAN 31 94 AND BEFORE JAN 31 96 a TOTAL of $290.00 is due. <********** *** LATE FEE

C13 00112771 13- 4/24/95 200.00
C13 00112772 13- 4/24/95 90.00

Please make check or money order payable to: COMMERCE AND CONSUMER AFFAIRS

OTHER REQUIREMENTS

OTHER REQUIREMENTS DUE or SPECIAL INSTRUCTIONS/INFORMATION:

Sign below to certify compliance with continuing education requirement. Failure to comply shall result in automatic forfeiture of license subject to restoration upon satisfaction of all appropriate requirements.

I hereby certify that I have completed approved continuing medical education as required by sections 453-6, Hawaii Revised Statutes and 16-85-34, Hawaii Administrative Rules. I understand that false statements or misrepresentation is a violation of section 453-8(a)(9)(15), Hawaii Revised Statutes and is grounds for refusal or subsequent revocation and/or disciplinary action against me.

3/25/95 Marilee Hanson, MD
DATE SIGNATURE OF LICENSEE

If licensed AFTER 12/31/92, no CMEs are required.

A license that has been forfeited for one renewal term (Two years) shall be automatically terminated and cannot be restored. A new application for licensure will be required.

(X) Address changed? Provide new mailing address here:
[redacted]

( ) Name changed? Check here and submit a copy of the name change document.

POSTED

RECEIVED
LICENSING BRANCH
MAR 30 11 00 AM '95
DEPT OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

TO BE COMPLETED BY LICENSEE

TO BE COMPLETED BY LICENSEE (Circle your answers and provide additional information where requested)

1) In the past 2 years has your license ever been formally disciplined by way of a suspension, restriction, or revocation? ..... Yes No
2) Are there any disciplinary actions pending against you? ..... Yes No
3) In the past 2 years have you been convicted of a crime? ..... Yes No
4) If response is 'Yes' to Question #3, has the conviction been annulled or expunged? Not applicable No

FOR ANY 'YES' RESPONSE ABOVE, PLEASE PROVIDE INFORMATION ON THE DATE, PLACE AND TYPE OF CONVICTION OR DISCIPLINARY ACTION ON A SEPARATE SHEET OF PAPER AND ATTACH TO THIS RENEWAL.

I understand that my license expires on the License Expiration Date shown on this form. I understand that if I fail to renew my license by the license expiration date I am unlicensed and shall not practice. I further understand that I may resume practice only after I have met all appropriate restoration requirements.

SIGNATURE OF LICENSEE Marilee Hanson, MD DATE 3/25/95

HAVE YOU REMEMBERED TO:
1) Attach payment.
2) Answer all questions.
3) Sign and date application.
4) If applicable, include required documents.

FOR DCCA ACCOUNTING OFFICE ONLY

TOTAL (ON TIME): 240.00
REN...300 ... 150.00
CRF...C13 ... 90.00

TOTAL (LATE): 290.00
REN...308 ... 200.00
CRF...C13 ... 90.00

LICENSE NO: MD 8555

$250.00 ON-TIME $200.00 LATE $250.00

DEFICIENCY NOTICE - Records Update

Return all required items with this notice to:

Date: 4/6/95

Board: of Medical Examiners

DCCA, PVL Licensing Branch
1010 Richards St., P. O. Box 3469
Honolulu, Hawaii 96801

MARILEE ANN HANSON
[redacted]

Your request to restore your medical license MD-8555 is being returned or ~~withheld~~ due to the following deficiencies listed below. Submit the required items immediately to process the changes on your records.

( ) Signature of Licensee
( ) Provide a residence/mailing address
(XX) Under/~~Over~~/No Payment. Submit the required fee of $ 290.00 .
Make check payable to COMMERCE & CONSUMER AFFAIRS
( ) Check written incorrectly: _____
( ) Form must be signed and notarized
( ) Fax/Photo copy of the letter or document is not acceptable. Submit the original.
( ) Submit a photocopy of the name change document (marriage certificate, name change decree, etc.) to change your name from _____ to _____ or complete the enclosed **"Name Change Affidavit"** form.
( ) Complete the enclosed application to relocate your business address. Submit with the required (highlighted) items on the instruction sheet.
( ) Submit a copy of the **"Application for Registration of Trade Name"** which has been file-stamped and accepted by the Business Registration Division, Commerce & Consumer Affairs.
( ) Your employer is not currently licensed
( ) Submit a letter of hire signed by your new employer
( ) Submit a letter of termination signed by your new employer
( ) Signature of employer is required
( ) Bond/Insurance is incomplete. Indicate the following: _____
( ) Submit the **"Client Trust Account"** letter
( ) Complete the enclosed **"Principal RME Designation"** form.
( ) Submit a 'sanitation clearance' issued by the State Department of Health attesting that the shop meets all sanitation and public health requirements.
( ) Unable to locate your files. Provide us of your license number.
( ) Respond no later than _____ for the changes to be backdated.
( ) OTHER: _____

RECEIVED
PVL
LICENSING BRANCH
APR 17 10 21 AM '95
DEPT OF COMMERCE
& CONSUMER AFFAIRS
STATE OF HAWAII

Hanson, Marilee

CHECK-OUT SHEET – PHYSICIAN

TEMPORARY LICENSE:

[ ] application
[ ] FEE -- $75 or $50
[ ] MD diploma
[ ] Hospital Affiliations:

[ ] intern cert (not I)
[ ] AMA clearance (not I/R)

INTERN-RESIDENT-GOVERNMENT:

[ ] employer verif letter

SPONSORSHIP:

[ ] sponsor stmt
[ ] exam fee
[ ] lic verif

ABSENCE - SHORTAGE:

[ ] county MD society stmt (optional)
[ ] lic verif

FOREIGN GRAD:

[ ] ECFMG or Fifth Pathway cert
[ ] 2 yrs training in U.S.:
_____ yrs _____ mos needed

Def. Notice sent _____
Def. Notice sent _____

LIC. NO.: _____
DATES
EFF.: _____ to _____
_____ to _____
_____ to _____

MD-04 793R

REGULAR LICENSE:

[✓] application
[✓] Fee: ~~$150~~ (2/1, odd to 1/31, even)
$250 (2/1, even to 1/31, odd)
[ ] Exam fee
[✓] MD diploma
[✓] Hospital Affiliations:
[✓] NPDB/Affidavit
[✓] intern/resident cert
[✓] ~~(NB cert or FLEX grades~~
[✓] AMA/Canadian clearance
[✓] other state license verifs:
[✓] Federation Discipline Report
(out-of-state license)

FOREIGN GRAD:

[ ] ECFMG or Fifth Pathway cert
[ ] ECFMG verification
[ ] 2 yrs training in U.S.:
_____ yrs _____ mos needed

EXAM
DATE: JUNE DECEMBER 19____

POSTED NOV 27 1993

Def. Notice sent _____
Def. Notice sent _____

LIC. NO.: 8555

EFF.: 11/10/93

OK

DEC -3 1993 MG

Duplicate renewal sent _____

Application for License – PHYSICIAN

FOR OFFICE USE ONLY

Read instructions and requirements on separate sheet before completing this form.

Name (First-Middle)	(LAST)
MARILEE ANN	HANSON

Texas off 11/15/93-1/2/94 MH

Mailing Address (include Apt. No. and zip code)

[redacted]

Social Security No.	Phone No. (days)	ID	00045447	13-11/17/93	150.00
[redacted]	[redacted]				

Birthplace (city/state/country)	Birth Date: Age:	Date AMA profile requested:
[redacted]	[redacted]	

Circle or underline answers and explain if needed:

1) Are you a graduate of a medical school whose M.D. program is accredited by the Liaison Committee on Medical Education, and have you attached evidence of completion? ..... (YES) NO
2) Have you attached evidence of residency of at least one year in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME)? ..... (YES) NO — Sent directly by program
3) Have you ever held a license in Hawaii? ..... YES (NO)
   If response "yes," specify type of license and dates below.
4) Has any medical license to practice in any state or country ever been revoked, suspended or otherwise subject to disciplinary action? ..... YES (NO)
   If response "yes," specify state where action took place, penalty imposed and reasons for such action on a separate sheet.
5) Are you presently being investigated or is any disciplinary action presently pending against you? ..... YES (NO)
   If response "yes," specify state where action is pending and reasons on a separate sheet.
6) Are you aware of any derogatory information about you in the file of any state licensing agency? ..... YES (NO)
   If response "yes," specify state where action is pending and reasons on a separate sheet.
7) In the past twenty years, have you been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES (NO)
   If response "yes," provide information on the date, place and type of conviction on a separate sheet.

Check LICENSE CATEGORY you are applying for:

X [ ] REGULAR license through EXAM. Circle exam date requested:
JUNE DECEMBER 19__

MD [X] REGULAR license through ENDORSEMENT *(NB or passed FLEX exam)*. Circle one:
(NATIONAL BOARD) FLEX

TEMPORARY CATEGORIES for those who do NOT have NB or FLEX credentials:

R [ ] RESIDENT
G [ ] GOVERNMENT *(will be employed by Hawaii state or county government agency)*
S [ ] SPONSORSHIP under direction of Hawaii physician with regular license not to exceed 18 months unless extended by the Board.
A/S [ ] ABSENCE or SHORTAGE *(absence or shortage of licensed physician in particular locality)*
E [ ] PUBLIC EMERGENCY

FOR COMPLETION BY ONLY GRADUATES OF MEDICAL SCHOOLS OTHER THAN IN U.S. OR CANADA:

Circle or underline answers. *Explain 'no' responses on separate sheet.*

Do you hold either of the following two certificates?
Educational Council for Foreign Medical Graduates (ECFMG) (current) certificate? ..... YES NO
Fifth Pathway certificate? ..... YES NO

Have you completed at least 2 years of medical training in an internship or residency program approved by the ACGME and have you attached your evidence? ..... YES NO

ALL OUT-OF-STATE LICENSES

Name of State(s)	Date Issued	License Number	Method of Licensure	Date 'Verification of License - MD' form mailed to state:	Date 'Federation Discipline Report' mailed to Federation:
CALIFORNIA	6/93	G076967	(NB) FLEX State Board Endorsement	Sept 93	Sept 93
			NB FLEX State Board Endorsement		
			NB FLEX State Board Endorsement		
			NB FLEX State Board Endorsement		

Continued on Back

Resident:	App/Lic	323/312	$ 25/$25	CRF	C13 ...	~~$ 50/$75~~ #25
Temp:	App/Lic	323/312	$ 25/$50	½ Ran	300 ...	$ 75
Exam:	App/Lic	323312	$ 50/$75	Service Fee	BCF ...	$7.50
	Exam	319	$ 520			
End:	App/Lic	323/312	$ (50/$75)			

EDUCATION & TRAINING

Name of College, Medical School, Institution	Location (City, State, County)	Dates (mo/yr) From	Dates (mo/yr) To	Precise Degree or Certificate Earned
University of California, Irvine	Irvine, CA Orange County	10/80	6/86	B.S. Biology
Stanford University	Palo Alto, CA	9/86	6/91	MD

HOSPITAL AFFILIATIONS
(Account for all time during the past 3 years. If more space is needed, use a separate sheet of paper.):

Name & Location of Hospital	Dates (mo/yr) From	Dates (mo/yr) To	Capacity Served	Date Requested Hospital to Complete Affiliation Form:
University of California, San Francisco	6/91	Present	OB/Gyn Resident	Sept 93

AFFIDAVIT OF APPLICANT:

The applicant Marilee Ann Hanson, MD (Name in Full) being first duly sworn upon his oath deposes and says: that he is the person herein named subscribing to this application; that he has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that there are no material omissions; that he is the lawful holder of the degree of Doctor of Medicine, that the same was procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) all government agencies (local, state, federal or foreign) to release to the Hawaii Board of Medical Examiners or its successors any information, files or records requested by that Board in connection with this application. I further authorize the Hawaii Board of Medical Examiners 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 further acknowledge that falsification of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

If I am an applicant for temporary license under "Sponsorship," I intend to take the regular licensing examination conducted by the Hawaii Board of Medical Examiners within the next 18 months as required by the state law. I understand that this temporary license is nonrenewable and may not be extended.

I understand that misrepresentation or breach of this certificate are grounds for refusal or subsequent revocation (Section 710-1017, Hawaii Revised Statutes).

Use a Stapler to Affix a Recent Photograph of Yourself Here.

(2" x 2", head & shoulders, front view)

Print your name on the back of the photograph.

Marilee Ann Hanson MD
Signature of Applicant

Subscribed and sworn to before me this 20th *day of* October, *19* 93

Gail J. Strack
Notary Public, State of California
My commission expires: 8-26-96

GAIL J. STRACK
Comm. #969502
NOTARY PUBLIC CALIFORNIA
City & County of San Francisco
Comm. Expires Aug. 26, 1996

MGC1

The Leland Stanford Junior University

to all to whom these Letters shall come Greeting

The Trustees and Faculty of the University, by virtue of the authority vested in them, have conferred on

Marilee Ann Hanson

who has satisfactorily pursued the Studies and passed the Examinations required therefor the Degree of

Doctor of Medicine

with all the Rights Privileges and Honors thereunto appertaining

Given at Stanford University in the State of California on the Sixteenth Day of June in the Year One Thousand Nine Hundred and Ninety-One the Two Hundred-Fifteenth Year of the Republic and the One Hundredth Academic Year of the University.

LELAND STANFORD JUNIOR UNIVERSITY ORGANIZED 1891

David Korn MD

School of Medicine
Founded as Cooper Medical College
by Levi Cooper Lane

President of the University

James C. Gaither

President of the Board of Trustees

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

RECEIVED
PVL
LICENSING BRANCH
JUN 28 2 56 PM '93
DEPT OF COMMERCE
& CONSUMER AFFAIRS
STATE OF HAWAII

Diplomate Name: Marilee Ann Hanson, MD

Date of Birth: [redacted]

Certification Date: 07/01/1992

Certificate #: [redacted]

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	[redacted]			PASS	[redacted]						

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME PART II	[redacted]			PASS	[redacted]					
NBME PART III	[redacted]			PASS						

DATE: 06/23/1993

SEE OTHER SIDE FOR SCORE INFORMATION

HI0239

This NBME *Endorsement of Certification* may include scores for Step 1 and Step 2 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE will replace both the current Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. Implementation of USMLE began with the administration of Steps 1 and 2 in 1992. The first administration of Step 3 will occur in June 1994. The NBME accepts passing scores on Parts I, II, and III as meeting the examination requirements for its certification program and the following combinations of passing scores on NBME examinations and USMLE: **Part I or Step 1 plus Part II or Step 2 plus Part III or Step 3.**

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE)

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

For all examinations, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Step 1 and Step 2, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Supervisor of Examinee Records.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - Determination was made by the USMLE Committee on Irregular Behavior that the examinee engaged in such behavior. Irregular behavior includes all actions on the part of applicants and/or examinees, or by others when solicited by an applicant and/or examinee, that subvert or attempt to subvert the examination process.

Score Not Yet Available - Score not available pending further review and/or analysis.

Special Testing Accommodations - Following review and approval of a request from the examinee, special testing accommodations were provided in the administration of the examination.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS, GYNECOLOGY
AND REPRODUCTIVE SCIENCES
SAN FRANCISCO, CA 94143-0132

JAMES D. GOLDBERG, M.D., DIRECTOR
RESIDENCY TRAINING PROGRAM
BOX 0132, M-1483, (415) 476-5192

LICENSING BRANCH
NOV 10 11 59 AM '93

November 8, 1993

TO: Board of Medical Examiners
DCCA, PVL Licensing Branch
1010 Richards St., P.O. Box 3469
Honolulu, HI 96813

FR: Residency Training Program
Department of OB/GYN
UCSF

RE: Marilee A. Hanson, M.D.

This will certify that the physician named above satisfactorily completed an internship in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco from June 21, 1991 to June 20, 1992.

Sincerely,

Susan McGuire
Residency Coordinator

APPLICANT

Name (First-Middle) (LAST)	Social Security No.	Birthdate
MARILEE ANN HANSON	[redacted]	

Address: [redacted]

Capacity Served or Applied for:
Intern and Resident

Date Served/Applied:
6/91 — present 9/93 to continue thru 6/95

To: CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

I am applying for a license to practice medicine and surgery in Hawaii. The board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency during any part of the 3 years preceding my application. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii State Board of Medical Examiners in connection with my application. Please complete the following questionnaire and PLEASE SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and return the material directly to the address on the reverse side.

RECEIVED OCT 4 1 5 PM '93 DEPT OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII PROFESSIONAL & VOCATIONAL LICENSING BRANCH

Date 9/15/93

Marilee Ann Hanson, MD
Signature of Applicant

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

Please type your responses. Answer yes/no questions by underlining your answer.

A. POSTGRADUATE TRAINING:

1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... (YES) NO
2. Briefly evaluate applicant's competence and conduct during the program: SURGERY SKILLS ADEQUATE FOR LEVEL OF TRAINING, WORKS WELL WITH COLLEAGUES & PATIENTS
3. Has the program ever had cause to restrict, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ..... YES (NO)
   If response "yes," please explain and attach copies of material from your records: _____

B. HOSPITAL PRIVILEGES:

1. Were privileges extended to the applicant? ..... (YES) NO
2. Please give start and end dates; and describe privileges: 6/21/91 TO PRESENT
3. Was applicant rejected privileges? ..... YES (NO)
   If response "yes," please explain and attach copies of material from your records: _____
4. Were privileges ever limited, revoked, suspended or restricted? ..... YES (NO)
   If response "yes," please explain and attach copies of material from your records: _____

C. SAFE PRACTICE COMMENTS:

1. Is there anything in your files which could call into question applicant's ability to safety practice medicine? ..... YES (NO)
   If response "yes," please explain: _____
2. Derogatory information, if any: _____

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION.

Date 9-27-93

James O'Donnell MD/cs
Signature of Chief of Staff or Administrator

Name JAMES J. O'DONNELL, MD
Title DEAN, POSTDOCTORAL AFFAIRS
Hospital UNIVERSITY OF CALIFORNIA SAN FRANCISCO
Address 505 PARNASSUS AVE. BOX 0410
SAN FRANCISCO CA 94143
Phone No. (415) 476-4552

HOSPITAL SEAL
(If none, please so indicate.)

(FOLD HERE)

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

(FOLD HERE)

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236

(916) 263-2653

November 4, 1993

Hawaii Medical Examiners
P. O. Box 3469
Honolulu, HI 96801

TO WHOM IT MAY CONCERN:

This is to verify that Dr. Marilee Ann Hanson, born on [redacted] was issued California physician and surgeon's certificate [redacted], on 6/28/93, based on National Board Credentials. The license is current and renewal fees are paid through 10/31/94. There is no current record of accusation and/or disciplinary activity.

Sandy Fugett
Division of Licensing

To expedite the verification process, the above is the standard format used by the Medical Board of California.

SEAL

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FEDERATION DISCIPLINE REPORT - PHYSICIAN

TO THE APPLICANT: All applicants for license are required to provide evidence that their licenses are in good standing. One form of evidence is the completion of this report by the Federation of State Medical Boards.

Complete the APPLICANT section and mail this form to:

Federation of State Medical Boards
6000 Western Place, Suite 707
Ft. Worth, TX 76107
(Attn: Barbara Raines)
Phone: (817) 735-8445

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APPLICANT

LAST NAME (CAPITAL LETTERS), First, Middle	Social Security No.	Birthdate
HANSON, MARILEE ANN	[redacted]	
Medical School of Graduation & Branch Location	**Date of Graduation**	
STANFORD UNIVERSITY SCHOOL OF MEDICINE	6/91	

I authorize the Federation of State Medical Boards to indicate on this form if there is any previous or pending disciplinary action against my licenses in any state.

Date 9/15/93

Marilee Ann Hanson, MD
Signature of Applicant

FEDERATION

TO THE FEDERATION: Please indicate below if there is any previous or pending disciplinary action against any licenses of the above-named individual.

PROFESSIONAL LICENSING BRANCH
OCT 25 10 35 AM '93
DEPT OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

OCT 22 1993

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Signature _____

Title _____

Date _____

PLEASE RETURN THIS FORM DIRECTLY TO THE HAWAII BOARD OF MEDICAL EXAMINERS. OUR ADDRESS BELOW MAY BE USED FOR MAILING IN A LEGAL (#10) WINDOW ENVELOPE:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

MD-07 '93

(FOLD HERE)

Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

(FOLD HERE)