MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

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

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

APPLICATION

(Check One)	(Check All That Apply)
☐ U.S. or Canadian Medical School Graduate	☒ Physician's and Surgeon's License
☒ International Medical School Graduate	☐ Postgraduate Training Authorization Letter (PTAL)
	☐ Update Application: File #
	☐ Limited Practice License

MBC Use Only: Application Type ☒

Honorably Discharged Veterans of the Armed Forces - Must supply satisfactory evidence to the Board that you have served as an active duty member of the Armed Forces of the United States and were honorably discharged.

Practice in Medically Underserved Area or Population - Must supply satisfactory evidence to the Board that you have accepted employment and intend to practice in an area of California formally designated as an underserved area or underserved population. Please see further details on our website at http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx.

Temporary License for Spouse of Active Duty Member of the Armed Forces - Must supply satisfactory evidence to the Board that you are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. In addition, you must meet the requirements listed in Business and Professions Code Section 115.6.

MBC Use Only: Priority Review ☐

PERSONAL INFORMATION

Type or Print Legibly

	Last	First	Middle	Suffix
1. Legal Name	Reissner	Hana	Rachel	

MBC Use Only: Legal Name ☒

2. Other Names/Alias

3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) [redacted] ☐ SSN ☐ ITIN

MBC Use Only: SSN/ITIN ☒

4. Date of Birth (mm/dd/yyyy) [redacted] 5. Gender ☐ Male ☐ Female

MBC Use Only: DOB ☒ Gender ☒

6. Address of Record

This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license.

If you are using a P.O. Box please list a confidential street address below.

Mailing Address *(40 characters maximum per line, including spaces)*: 4551 Pennsylvania Ave. Apt 1411

Mailing Address continued *(40 characters maximum per line, including spaces)*:

City	State/Province	Zip/Postal Code	Country
Kansas City	MO	64111	USA

MBC Use Only: Address of Record ☒

Confidential Address (Only required if Address of Record is a P.O. Box)

MBC Use Only: Confidential Address ☐

7. Telephone Numbers: Home # [redacted] Work # [redacted] Cell # [redacted]

MBC Use Only: Telephone Numbers ☒

8. E-mail Address (Required) [redacted]

MBC Use Only: Email ☒

9. Have you served or are you currently serving in the military? ☐ Yes ☐ No

10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces? ☐ Yes ☐ No

MBC Use Only: Military ☒

MBC Use Only Cashiering	Pathway	School Code
6942873/1-4743/107.50 2/22/19	2102	1SR02

L1A

07A-100 (Revised 01/2019)

BS 2/25/19

APPLICANT: (Print Legal Name) Hana Reissner

DATE OF BIRTH (mm/dd/yyyy) [redacted]

MBC Use Only ☑ Name & DOB

NOTE: A "yes" response to question 11 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	[redacted]Yes [redacted]No	Previous App/License ☑
12. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	☐Yes ☒No	☑
13. Are you certified by the Educational Commission for Foreign Medical Graduates?	☒Yes ☐No	ECFMG ☑

14. List all of the following examinations you have taken and passed: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**

Examination	Date Passed	Exams
USLME Step 1	[redacted]	☑
USLME Step 2 CK		☑
USLME Step 2 CS		☑
USLME Step 3		☑

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school, you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code. To view the Board's list of recognized or approved medical schools, please refer to our website at: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx.

15. List each medical school that you have attended and the medical school of graduation.

Medical Education

Medical School Name	Mailing Address	Dates of Attendance (mm/dd/yyyy)		L2	Trans	School Code
Tel Aviv University, Sackler School of Medicine, New York/American Program	17 East 62nd St, New York, NY 10065	Start	9/4/2011	☑	☑	1SR02
		End	5/11/2015			
		Start		☐	☐	
		End				
		Start		☐	☐	
		End				

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma
Tel Aviv University Sackler School of Medicine, New York/American Program	M.D.	[redacted] 5/11/2015	☑

L1B

APPLICANT: (Print Legal Name) Hana Reissner

DATE OF BIRTH: (mm/dd/yyyy) [redacted]

MBC Use Only ☑ Name & DOB

(Internship, Residency and Fellowship Programs)

PG Training Programs ☑

16. Have you participated in any ACGME-accredited postgraduate training programs in the United States or RCPSC-accredited postgraduate training in Canada? *(If NO, please skip to question #24)* ☑ Yes ☐ No

List every program (internship, residency and fellowship) in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.
(Use the *Addendum to Question #16 Form* if additional space is needed)

Facility Name	City, State/Province	Specialty	Dates of Training (mm/dd/yyyy)	
University of Kansas Medical Center	Kansas City, KS	08164N	Start	7/1/2015
			End	6/30/2019
			Start	
			End	
			Start	
			End	

NOTE: A "yes" response to question 17-23 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

17. Have you ever received partial or no credit for a postgraduate training program?	☐
18. Have you ever taken a leave of absence or break from your training?	☐
19. Have you ever been terminated, dismissed or expelled from a program?	☐
20. Have you ever been placed on probation for any reason?	☐
21. Have you ever been disciplined or placed under investigation?	☐
22. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐

MEDICAL LICENSE

License ☑

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province? ☑ Yes ☐ No

List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses. (Use the *Addendum to Question #24 Form* if additional space is needed.)

U.S. State, U.S. Territory or Canadian Province	License Number	Dates of Practice (mm/yyyy to mm/yyyy)	
Kansas	94-08749	7/1/2015	to 6/30/2019
			to
			to
			to

☑ RESIDENT

L1C

APPLICANT: (Print Legal Name) Hana Reissner	DATE OF BIRTH: (mm/dd/yyyy) [redacted]	MBC Use Only ☑ Name & DOB
25. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☑ No	ABMS ☑
MALPRACTICE HISTORY		
26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgment, or arbitration?	[redacted]	Malpractice History ☑
DISCIPLINARY HISTORY		
These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state, U.S. territory, Canadian province, or foreign country.		Disciplinary History
27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?	[redacted]	☑
28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?		☑
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?		☑
30. Have you ever been denied a license to practice medicine?		☑
31. Is any denial pending against you?		☑
32. Have you ever had any license to practice medicine subjected to any disciplinary action?		☑
33. Is any disciplinary action pending against any of your licenses to practice medicine?		☑
34. Have you ever surrendered a license to practice medicine?		☑
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?		☑
36. 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?		☑
37. 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?		☑
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?		☑
39. Is any disciplinary action pending against your hospital or staff privileges?		☑
40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?		☑
41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?		☑

NOTE: A "yes" response to question 26-41 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

L1D

APPLICANT: (Print Legal Name) Hana Reissner	DATE OF BIRTH: (mm/dd/yyyy) [redacted]	MBC Use Only ☑ Name & DOB

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction, you must submit certified copies of the arresting agency report, certified copies of the court documents (court docket) and a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal History

42. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	[redacted]	☑
43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	[redacted]	☑
44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	[redacted]	☑
45. Are you a registered sex offender?		☑

PRACTICE IMPAIRMENT OR LIMITATIONS

Please note that an affirmative answer to any of the questions below will not automatically disqualify you from licensure. The Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a Limited Practice License may be available. Refer to the Application Information for a Limited Practice License for further information.

Limitations

46. Have you ever been diagnosed with an emotional, mental, behavioral, or addictive disorder that impairs your ability to practice medicine safely?	[redacted]	☑
47. Have you ever been diagnosed with a neurological or other physical condition that impairs your ability to practice medicine safely?		☑
48. Do you have any other condition that in any way impairs or limits your ability to practice medicine safely?		☑

NOTE: A "yes" response to question 42-48 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

L1E

[redacted]

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

MBC Use Only

Rev L1A-F Staff Initials & Date CR 3/21

Photograph ☑

Applicant Name & DOB ☑

DECLARATION

The applicant, Hana Rachel Reissner [redacted],
PRINT LEGAL NAME (First, Middle, Last, Suffix) (dd/yyyy)

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ☑

SIGN LEGAL NAME: [signature] **DATE:** 2/1/19

NOTARY SECTION

Applicant Signature ☑

SIGNATURE OF APPLICANT: [signature]
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of KANSAS

County of WYANDOTTE

Subscribed and sworn to (or affirmed) before me on this 1ST day of FEBRUARY, 2019,

by, HANA RACHEL REISSNER proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

[signature]
SIGNATURE OF NOTARY PUBLIC

Applicant Name & Notary Date ☑

NOTARY SEAL #1154423
Melissa Vazzano
Notary Public
State of Kansas
My Appointment Expires on 12/03/2022

Notary Signature & Seal ☑

L1F

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TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide the Board with a written chronological description of all your professional and non-professional activities. Please 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. *Please use as many forms as necessary to provide a complete timeline of activities.*

Type or Print Legibly — **PERSONAL INFORMATION**

LEGAL NAME: Last	First	Middle	Suffix
Reissner	Hana	Rachel	

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Tel Aviv University Sackler School of Medicine, New York/American Program

Start Date	End Date	Location (Provide Facility Name, Address, and Supervisor)	Activities	MBC Use Only
7/1/2015	6/30/2019	University of Kansas Medical Center 3901 Rainbow Blvd. Kansas City, KS 66160. Supervisor: Dr. Carrie Wrenehe	OB/GYN Residency	☑
				☐
				☐
				☐
				☐

SIGN LEGAL NAME: [signature] DATE: 2/1/19

Applicant's signature and date are required.

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CERTIFICATE OF MEDICAL EDUCATION

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

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Reissner	Hana	R	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Sackler School of Medicine

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 be mailed directly to the Board from the medical school.

1. Name of Medical School	Sackler School of Medicine, NY Program
2. State/Province/Country	Tel Aviv, Israel

3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 ***years*** of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2).

Alcoholism and Chemical Dependency	Geriatric Medicine	Otolaryngology	Psychiatry
Anatomy	Histology	Pain Management and End-of-Life-Care**	Radiology, including Radiation Safety
Anesthesia	Human Sexuality	Pathology, Bacteriology, and Immunology	Spousal Partner Abuse Detection & Treatment***
Biochemistry	Medicine	Pediatrics	Surgery, including Orthopedic Surgery
Child Abuse Detection and Treatment	Neuroanatomy	Pharmacology	Therapeutics
Dermatology	Neurology	Physical Medicine	Tropical Medicine
Embryology	Obstetrics and Gynecology	Physiology	Urology
Family Medicine*	Ophthalmology	Preventative Medicine, including Nutrition	

*ONLY applicable to medical students who enrolled in medical school on or after May 1, 1998
**ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000
***ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994

4. Did the applicant withdraw or transfer from this medical school?	☐ Yes ☒ No
5. What is the standard duration of the curriculum at this institution?	4 years
6. Date the applicant was enrolled in medical school?	(mm/dd/yyyy) 09/04/2011
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine	(mm/dd/yyyy) 05/11/2015

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

8. Did this applicant ever take a leave of absence from his/her medical education?	[redacted]
9. Was this applicant ever placed on probation?	
10. Was this applicant ever disciplined or placed under investigation?	
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Tami Lipkin-Zur, Registrar	
SIGNATURE OF SCHOOL OFFICIAL	**DATE**
Tami Lipkin-Zur	14 February 2019

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MBC Use Only
Applicant Information ☑
Medical School Information
School Code: 1SR02 ☑ ☑
Rev. L2 Staff Initials & Date: GR 3/21 ☑ ☑ ☑ ☑
Unusual Circumstances ☐ ☑ ☑ ☑
School Seal ☑
Signature and Date ☑
L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☑ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Reissner	Hana	Ruehel	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Sackler School of Medicine

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	University of Kansas School of Medicine Program		
Facility Address	3901 Rainbow Boulevard, Wescoe 3rd Floor Kansas City, KS 66160		
Specialty	OBGYN	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	2201911103
Dates of Training (mm/dd/yyyy)	Start Date: 7/1/2015	End Date (or anticipated completion date): 6/30/2019	

UNUSUAL CIRCUMSTANCES

***Program Director*: Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

1. Did the applicant receive partial or no credit during his/her postgraduate training?	[redacted]
2. Did the applicant ever take a leave of absence or break from his/her 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. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	

GENERAL MEDICINE TRAINING REQUIREMENT

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

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four (4) months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete **four (4) months** of training in GENERAL MEDICINE prior to licensure. *The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.*

MBC Use Only

- Applicant Information ☑
- Verified Program Information ☑
- ☑ ☑
- Unusual Circumstance
- ☑
- ☑
- ☑
- ☑
- ☑
- ☑
- ☑
- Gen Med Required
- ☑

L3A

APPLICANT INFORMATION

LEGAL NAME: Last: Rezsner | First: Hana | Middle: Ruehel | Suffix:

MBC Use Only — Applicant's Name ☑

ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Verified PD Staff Initials & Date: GR 5/3

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 or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Carrie Wieneke
PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

4/1/19
DATE

Program Director's Signature & Date ☑

NOTE: **If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.**

Program Director's Signature ☑

SIGNATURE OF PROGRAM DIRECTOR: _____
(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of KANSAS

County of WYANDOTTE

Subscribed and sworn to (or affirmed) before me on this 1ST day of April, 2019,

by, Carrie Wieneke proved to me on the basis of satisfactory evidence
(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

_____
SIGNATURE OF NOTARY PUBLIC

Notary Signature & Seal ☑

Hospital Seal ☐

HOSPITAL or NOTARY SEAL

STATE NOTARY PUBLIC KANSAS

Melissa Vazzano #1154423
Notary Public
State of Kansas
My Appointment Expires on 12/08/2020

L3B

NOTE: The completed forms must be mailed directly from the program to the Board to be acceptable.

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

Kansas
State Board of Healing Arts

PHONE: 785-296-7413
FAX: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Kathleen Selzler-Lippert, Executive Director

Laura Kelly, Governor

March 19, 2019

Medical Board of California, Licensing Program
2005 Evergreen St. Ste 1200
Sacramento, CA 95815

This is to certify that: Hana Rachel Reissner has been licensed to practice in Kansas in the following profession: Medical Doctor Postgrad Permit

License Number:	94-08749
Date of Birth:	11/28/1986
Profession:	Medical Doctor Postgrad Permit (MD)
License Status:	Active - Current
Original License Date:	06/23/2015
Expiration Date:	06/30/2019

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Disciplinary Action: NONE

Verified by:

Marisa Ashley

Marisa Ashley
Phone: (785) 296-3146
Email: Marisa.M.Ashley@ks.gov

MEDICAL BOARD OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

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

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CERTIFICATE OF CLINICAL TRAINING

(This form is only required of international medical school graduates)

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Reissner	Hana	R	

Date of Birth (m/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Sackler School of Medicine

MBC Use Only
Applicant Information ☐

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Report undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING. *Please use as many forms as necessary to document ALL undergraduate clinical clerkships completed during enrollment in medical school.*

Note: Section 2089.5(c) of the Business and Professions Code requires that instruction in the clinical courses shall total a minimum of 72 weeks. Instruction in the core clinical courses shall total a minimum of 40 weeks in length with a minimum of **(8)** weeks of medicine, **(8)** weeks of surgery, **(6)** weeks of pediatrics, **(6)** weeks of ob/gyn, **(4)** weeks of psychiatry, and **(4)** weeks of family medicine. (Family Medicine is required for applicants who graduated after May 1, 1998)

Rev. L5 Staff Initials & Date

Clinical Subject (List one subject per line)	Facility Name City/State/Province/Country	Dates of Attendance in Chronological Order (mm/dd/yyyy)	Weeks or Weekly Clinical Hours
Please see attached		Start:	
		End:	☐
Clinical Listing		Start:	
		End:	☐
		Start:	
		End:	☐
		Start:	
		End:	☐
		Start:	
		End:	☐
		Start:	
		End:	☐

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Tami Lipkin-Zur	Registrar
SIGNATURE OF SCHOOL OFFICIAL	**DATE**
Tami Lipkin-Zur	14 February 2019

School Seal ☐
Signature and Date ☐

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

L5

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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Certificate of Individual Clinical Clerkship Training

This form is required of international medical school graduates who completed any clinical training outside of the primary teaching hospital of their medical school. A separate form is to be used for each clinical clerkship.

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
REISSNER	HANA	RACHEL	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	SACKLER SCHOOL OF MEDICINE

PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION

Facility Name	Facility Address
Montefiore - Einstein	1825 Eastchester Road, Bx NY 10461
Clinical Specialty	**Dates of Training** (mm/dd/yyyy)
OBGYN - Ultrasound	Start Date: 07/21/2014 End Date: 08/15/2014

This facility is formally affiliated or has a formal contract of affiliation with a U.S., Canadian, or International Medical School. ☑ Yes ☐ No

Name of the U.S., Canadian, or International Medical School. **(If affiliated)** Albert Einstein College of Me

This facility **does** have an ACGME-accredited residency training program. ☑ Yes ☐ No

ACGME 10-digit program # (https://apps.acgme.org/ads/Public): 2203521178 Specialty: OBGYN

OFFICIAL CERTIFICATION

ATTENTION: A signature stamp is not acceptable. THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or clinical instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

I certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

STACI E. Pollack, MD
PRINTED NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR

[signature] MD
SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR

04/25/19
DATE

NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public.

Signature of Program Director or Clinical Instructor: [signature] MD
(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of New York County of Bronx

Subscribed and sworn to (or affirmed) before me on this 25 day of April, 20 19,

by, Staci E. Pollack, M.D proved to me on the basis of satisfactory evidence
(Print Name of Program Director or Clinical Instructor)

to be the person who appeared before me.

[signature]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL
NOTARY PUBLIC, STATE OF NEW YORK
No. 01OR6079341
QUALIFIED IN BRONX COUNTY
MY COMMISSION EXPIRES AUG. 26, 20 22

MBC Use Only
Applicant Information ☑
Verified Information with L5 ☑
Clerkship Approved ACGME OBGYN OK
Rev L6 Staff Initials & Date 4/25/19
Signature & Date ☑
Signature ☑
Notary Signature & Seal ☑
Hospital Seal ☐

L6

NOTE: The completed form must be mailed directly from the facility to the Board to be acceptable.

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Certificate of Individual Clinical Clerkship Training

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APPLICANT INFORMATION

LEGAL NAME: Last: Reissner First: Hana Middle: Rachel Suffix:

Date of Birth (mm/dd/yyyy): [redacted] Last 4 Digits of U.S. SSN or ITIN: [redacted] Medical School of Graduation: Saint School of Medicine

FACILITY INFORMATION

Facility Name	Facility Address
Beth Israel Mount Sinai	281 1st Ave, NY, NY 10003

Clinical Specialty	Dates of Training (mm/dd/yy)
OB/GYN	Start Date: 09/08/14 End Date: 10/03/14

This facility is formally affiliated or has a formal contract of affiliation with a U.S., Canadian, or International Medical School: ☒ Yes ☐ No

Name of the U.S., Canadian, or International Medical School (if affiliated): Icahn School of Medicine at Mount Sinai

This facility does hold an ACGME-accredited residency training program: ☒ Yes ☐ No

ACGME 10-digit program # (www.acgme.org): 1403531288 Specialty: OB/GYN

ATTENTION: A signature stamp is not acceptable. THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or clinical instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on an official letterhead and must be dated within the last 12 months.

I certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

Michelle Sainte . Associate Dean MedEd
PRINTED NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR

[signature] 4/25/2019
SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR DATE

NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public.

Signature of Program Director or Clinical Instructor: ______________________
(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of ______________________ County of ______________________

Subscribed and sworn to (or affirmed) before me on this ________ day of ______________, 20______,

by ______________________ proved to me on the basis of satisfactory evidence
(Print Name of Program Director or Clinical Instructor)
to be the person who appeared before me.

HOSPITAL or NOTARY SEAL

____
SIGNATURE OF NOTARY PUBLIC

MBC Use Only: Applicant Information ☑; Verified Information with LS ☑; Clerkship: ACGME OK; Rev'd Cmt Initials & Date 9/25/19; Signature & Date ☑; Signature ☐; Notary Signature & Seal ☐; Hospital Seal ☑

wrong dates used 2107. TH

L6

NOTE: The completed form must be mailed directly from the facility to the Board to be acceptable.

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**162871**
File Number:	**2043607**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14847208**
Application Date:	**06/21/2021 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**HANA**
Middle Name:	**RACHEL**
Last Name:	**REISSNER**
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]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 20-29 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 90033 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: 90033 County: LOS ANGELES**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Postgraduate Training Years	**7 Years**
Cultural Background	[redacted]
	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$820.00**

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: