002760

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

EDMUND G. BROWN JR., Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
ALLIED HEALTH PROFESSIONS (916) 322-5043
APPLICATIONS AND EXAMINATIONS (916) 322-5040

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE JUN 23 10 54 AM '79

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE BASED ON NATIONAL BOARD CREDENTIALS CLASS G

B132 [illegible]

007655

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME: Last: ROBINSON First: SUSAN Middle: CELINA
2. Telephone No.
3. List other names, if any, you have used: SUSAN SANDPERL SUSAN BAIN
4. Address: Street and No./Rural Route: 701 COLIMA ST City: LA Jolla State: Ca Zip Code: 92037
5. Name you wish on License: SUSAN CELINA ROBINSON

Birthdate: (Month - Day - Year)

6. Premedical Education: Name of College or University: MONTEREY PENINSULA COLLEGE; UNIVERSITY OF CALIFORNIA

Location: MONTEREY CA.; SANTA CRUZ CA.

Period of attendance: From: JAN '70 To: APRIL '72; From: APRIL '72 To: JUNE '74

Check premed courses successfully completed: ☑ Chemistry ☑ Physics ☑ Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	UNIVERSITY OF CALIFORNIA	SAN DIEGO	SEPT 74	JUNE 75
2nd	" " "	" "	SEPT 75	AUG 76
3rd	" " "	" "	SEPT 76	AUG 77
4th	" " "	" "	SEPT 77	JUNE 78
5th				
6th				

8. Doctor of Medicine Degree granted by: UNIVERSITY OF CALIFORNIA at SAN DIEGO Sch. of Med. Date: JUNE 18 1978

For office use only School Code: CA017

9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
UNIVERSITY OF CALIFORNIA, SAN DIEGO MED CENTER	SURGERY	6/24/78	6/24/79

10. List all States in which you have been licensed to practice medicine: none

11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held?

If Yes, indicate below: N/A

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country?

If Yes, indicate below: N/A

State or Country	Date of Denial	Reason for Denial

13. Are you now or have you ever been addicted to narcotic drugs?

07A-161 (REV. 2-77)

(Over)

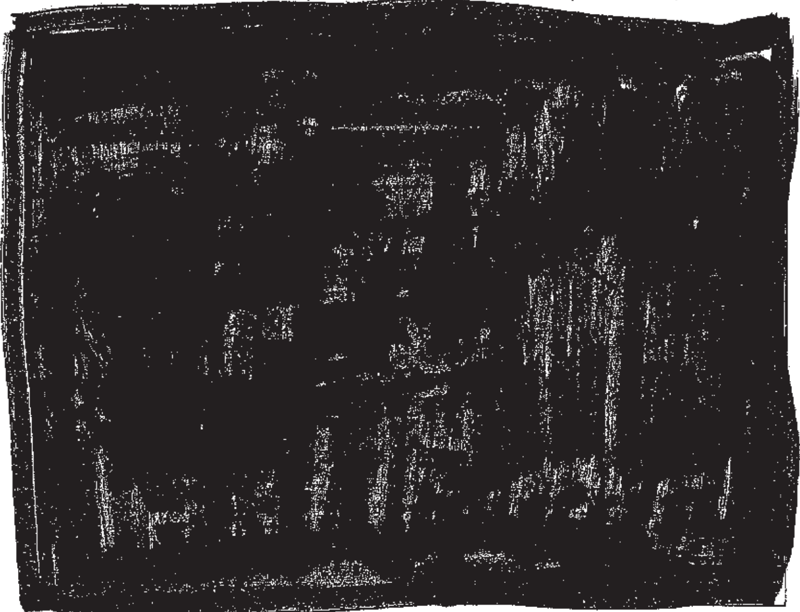
14. Have you ever been convicted of, or pled nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction?

15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information: N/A

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If yes, please explain on another sheet of paper.



Applicant: Please complete the following:

Height: ___Ft. ___In. Weight: ___Lbs.

Hair color: ___ Eye color: ___

Identifying marks: ___

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

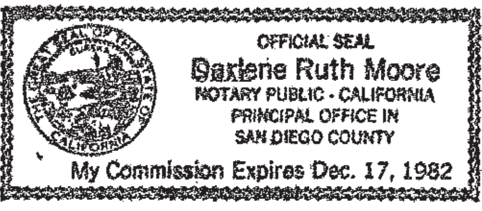
Signature of Applicant Susan C Robinson MD

Date June 19, 1979

Subscribed and sworn to before me this 19 day of June 1979

Signature of Notary Darlene Ruth Moore

Address 225 Dickinson Street San Diego Calif 92103



My commission expires: December 17, 1982

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

EDMUND G. BROWN JR., Governor

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
APPLICATIONS AND EXAMINATIONS
(916) 920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Susan Celina Robinson
Full name of applicant

enrolled in University of California, San Diego, School of Medicine
Name of medical school (college)

on the 16 day of September 19 74.
Month Year

[X] as a Freshman.

[ ] with advanced standing based on ______
Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

[X] PHYSICS [X] CHEMISTRY [X] BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at University of California, Santa Cruz, and that he attended while at this
Please indicate school

medical school (college) all required courses of lectures of 176 weeks ~~each~~,
Specify number Specify number of weeks

completing 4000 + hours in the subjects below listed, and that he/she:
Total hours

[X] was granted the degree { ~~Bachelor~~ / Doctor } of Medicine

[ ] left the above mentioned medical school (college) for the following reason(s):

______

______

on the 18 day of June 19 78.
Month Year

Please indicate which of the following courses of study were successfully undertaken by the applicant:

X Anatomy
- X Embryology
- X Histology
- X Neuroanatomy

X Physiology

X Psychobiology

X Biochemistry

X Pathology, bacteriology and immunology

X Pharmacology

X Preventive medicine
- X Hygiene and sanitation

X Radiology, including roentgenologic technique and radiation safety

X Urology

X Ophthalmology

X Anesthesia

X Otolaryngology

X Obstetrics and gynecology

X Medicine
- X Pediatrics
- X Psychiatry
- X Neurology
- X Dermatology
- X Physical medicine
- X Therapeutics
- X Tropical medicine

X Surgery, including orthopedic surgery

Signed and the College seal affixed this 13 day

of June 19 79.
Month Year

[AFFIX SEAL HERE]

By [signature] MD
President, Secretary, Dean

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/26/2013 **To Date:** 01/26/2013

ATRISUPPINF

23-MAR-16 15:54:18

Person Id : 590369 **Name :** Robinson,Susan

Question	**Answer**
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License, Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
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?	

Total Questions Asked For Person : 590369 8

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER APRIL 30, 2015
ROBINSON, SUSAN C	**G39852**	**03/31/15**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side) N/A
- "I" [ ] Conviction Disclosure – Yes N/A
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [X] Financial Interest Statement-Read instructions above

"D" **SIGNATURE REQUIRED**

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature Susan C Robinson MD Date 12/29/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060003985290103311500082000000089800

CHANGE OF MAILING ADDRESS **ROBINSON, SUSAN C** **G39852**

01072015 20001260 20020009

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip

PO Box (if used, must provide a confidential physical street address, above)

City State Zip