STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

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

Rec'd 10/11/90

APPLICATION UPDATE FOR EXAMINATION OR LICENSURE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application including Form L7. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

PERSONAL DATA

1. Name — Last: TORBATI First: KAMRAN Middle: —

2. Other names you have used: —

3. Address: Name and Street/Rural Route (include apartment number, if any)
c/o TORBATI 18440 HATTERAS ST. # 204
City: TARZANA State: CA ZIP Code: 91354 Country: USA

4. Telephone Number: Home Work

5. Social Security Number (See disclosure statement on reverse)

POSTGRADUATE TRAINING

6. Have you received qualifying postgraduate training in U.S. or Canadian facilities? [X] Yes [ ] No

If yes, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility if this has not been provided previously.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	
AC/USC Medical Center	Los Angeles, CA	Internship in Medicine	7.88	6.89	✓
Sinai Hospital	DETROIT, Michigan	Residency in OB/GYN	7.89	present	✓

LICENSE DATA

7. Have you been licensed to practice medicine in any state or country? [X] Yes [ ] No

If yes, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed if requested or if this has not been provided previously.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)	LGS	CE
MICHIGAN	4301055016	7.90	7.90	present		
			as OBGYN	Resident		

8. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.
Yes No If yes, please explain on a separate sheet of paper. Include the date, charge and disposition. ✓

9. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No ✓
If yes, please explain on a separate sheet of paper. Include state or country, date of denial and reason for denial.

10. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?
Yes No If yes, please explain on a separate sheet of paper. ✓

11. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?
Yes No If yes, please explain on a separate sheet of paper. ✓

12. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No If yes, please explain on a separate sheet of paper. ✓

L8A

BMQA USE ONLY

GENERAL DATA

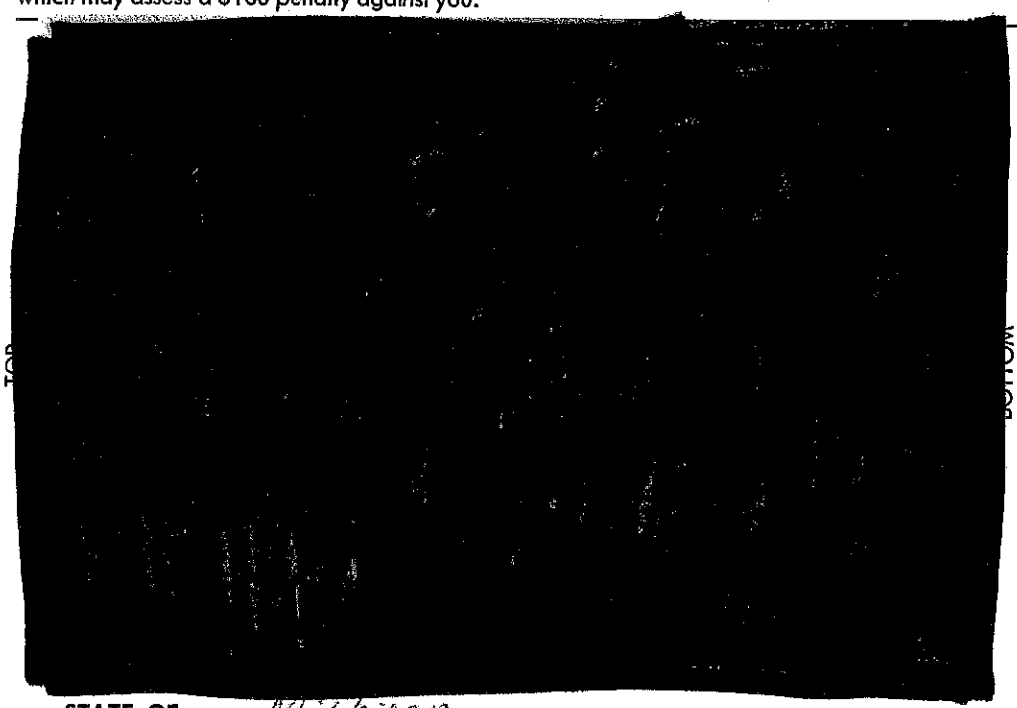
13. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No If yes, please explain on a separate sheet of paper.

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, or to drug addiction? Yes No
If yes, please explain on a separate sheet of paper. Include the violation, location, date, and penalty or disposition.

15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)
Yes No If yes, please explain on a separate sheet of paper. Include the violation, location, date, and penalty or disposition.

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405(c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."



I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about _____, 19__,

my age then being _____ years;

color of hair _____;

color of eyes _____;

height _____ ft. _____ in.;

weight _____ lbs.;

identifying marks _____

STATE OF Michigan)
COUNTY OF WAYNE)

KAMRAN TORBATI being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 10 day of October, 19 90.

[SEAL]

Signature of Notary Public Katherine M. Waltzer

Address Sinai Hospital, 6767 W. Outer Drive, Detroit

My commission expires March 14, 1994

KATHERINE M. WALTZER
NOTARY PUBLIC - MACOMB COUNTY, MICH.
MY COMMISSION EXPIRES 03-14-94

88 47759

L8B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN *Governor*

DEPARTMENT OF Consumer Affairs

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

APPLICATION FOR EXAMINATION AND UPDATE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application including Form L7. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. This request is made in connection with an application now on file with this Board for:
   - [x] A. Permission to take the following examination:
     - [ ] written examination
     - [ ] reciprocity written examination
     - [x] oral and clinical examination
   - [x] B. Update of my application

2. Name — Last: TORBATI First: KAMRAN Middle: -

3. Other names you have used:

4. Address: Name and Street/Rural Route (include apartment number, if any)
New mailing address: 18440 HATTERAS ST. #204

City: TARZANA State: CA ZIP Code: 91356 Country: U.S.A.

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

7. Have you been licensed to practice medicine in any state or country? [x] Yes [ ] No
If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction		LGS	CE
			From (Mo/Yr)	To (Mo/Yr)		
Israel	R/1/018111	2.10.85	None			

8. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.
[ ] Yes [x] No If yes, give details below:

State	Date	Charge	Disposition

9. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No
If yes, give details below:

State or Country	Date of Denial	Reason for Denial

10. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?
Yes No If yes, please explain on a separate sheet of paper.

11. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No If yes, please explain on a separate sheet of paper.

TYPE / PERSONAL DATA / LICENSE DATA

07A-43 (Rev. 1/86)

L8A

BMQA USE ONLY

12. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

Yes No

13. 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, or to drug addiction? Yes No

If yes, give details below:

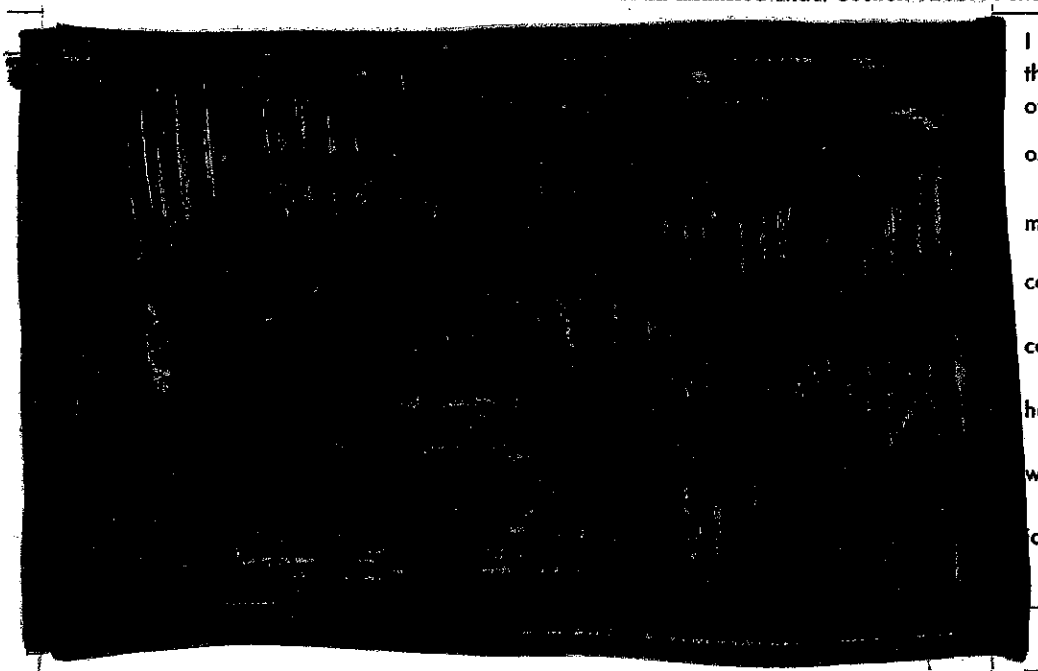
Violation and Location	Date	Penalty or Disposition

14. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

Yes No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.



I hearby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about____ , 19.

my age then being_____ years;

color of hair____

color of eyes____

height_____ ft._____ in._____ ;

weight_____ __ lbs.;

identifying marks _

STATE OF California)
COUNTY OF Los Angeles)

KAMRAN TORBATI being duly sworn, says __he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that __he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

K Torbati

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 20 day of June, 19 89.

Signature of Notary Public Catherine E. Bergren

[SEAL] OFFICIAL SEAL
CATHERINE E BERGREN
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY

Address 1200 N. State Box 510 L.A. 90033

My commission expires Feb 24, 1993

86 (39 03)

L8B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

BOV 003587 180.00 9/90

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE 88 MAR 2 11 03 AM '88

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

008134 305.50 3/88

BMQA USE ONLY

PERSONAL DATA

1. Name: Last: TORBATI First: KAMRAN Middle: —

2. Other names you have used: — None

3. Social Security Number (See disclosure statement on L1C)

4. Address: Number and Street/Rural Route (include apartment number, if any): 7624 Fountain Ave #H, Los Angeles, CA, 90046

City: Los Angeles State: CA ZIP Code: 90046 Country: U.S.A.

5. Telephone Number: Home: Work: —

6. Date of Birth: Mo/Day/Yr

7. Sex: ☐ Female ☒ Male

8. Are you a U.S. citizen? ☐ Yes ☒ No
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If YES, give date of previous application:

NON-MEDICAL EDUCATION

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
None			

MEDICAL EDUCATION

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	CME	TRANS.
Sackler sch. of Med.	Tel-Aviv. Israel	Tel-Aviv University	10/1981	6/1986	☑	☑
Tehran Univ. sch. of Med	Tehran - Iran	Tehran Univ.	10/1976	6/1980	☐	☑
					☐	☐

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance	School Code
Sackler School of Med. Univ of Tel. Aviv	Tel-Aviv, Israel	7.1.1986	ISR 02

L1A

07A-100

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
FMGEMS II	L.A., CA.	July 1986	
FMGEMS I	Honolulu, Hawaii	July 1987	
FLEX I & II	Philadelphia, PA	June 1987	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☐ Yes ☒ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

POSTGRADUATE TRAINING

Completed PGY 1 6/23/89 OK

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)

15. Have you been licensed to practice medicine in any state or country? ☒ Yes ☐ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction		LGS	CE
			From (Mo/Yr)	To (Mo/Yr)		
Israel	R/1/ 018 111	10-2-85	Left Israel a few days			
			before the issuance!			

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

Yes No If yes, give details below:

State	Date	Charge	Disposition

L1B

BMQA USE ONLY

LICENSE DATA (continued)

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

Yes No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

Yes No If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No If yes, please explain on a separate sheet of paper.

GENERAL DATA

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No If yes, please explain on a separate sheet of paper.

22. 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, or to drug addiction? Yes No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

Yes No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

TOP

BOTTOM

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ____ _____, 19____,

my age then being ____ years;

color of hair ____;

color of eyes ____;

height ____ ft. ____ in.;

weight ____ lbs.;

identifying marks ____

NOTE: 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, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF California)
COUNTY OF Los Angeles)

KAMRAN TORBATI being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

K. Torbati M.D.
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 29TH day of FEBRUARY, 1988.

[SEAL] OFFICIAL SEAL
RENE J. BUCHANAN
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Exp. June 17, 1988

Signature of Notary Public Rene J. Buchanan

Address 300 S. FAIRFAX, LA, CA 90066

My commission expires 6-17-88

L1D

07A-100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

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

RECEIVED SACRAMENTO MEDICAL STATE

26 JUN 89 11 54

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that KAMRAN TORBATI (NAME OF APPLICANT),

a graduate of Sackler School of Medicine in Tel-Aviv University (NAME OF MEDICAL SCHOOL),

commenced postgraduate training in LAC/USC MEDICAL CENTER (NAME AND ADDRESS OF FACILITY),

1200 North State Street, Los Angeles, CA,

on June 24, 19 88, and completed such training

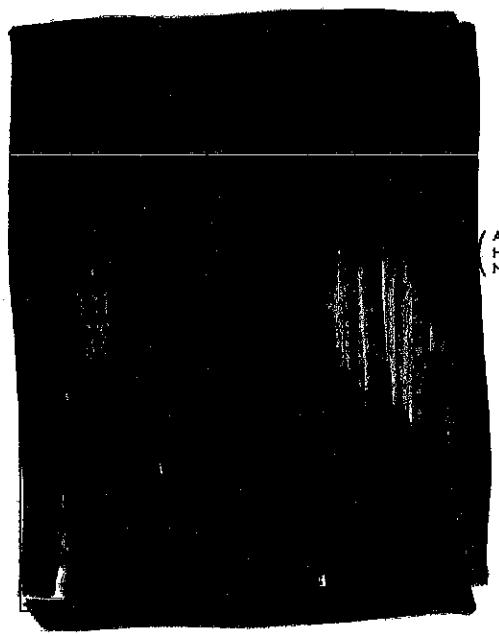
on June 23, 19 89. This training consisted of 11 months of actual

clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Internal Medicine	there are 13 four-week rotations

4 weeks Pulmonary, 4 weeks Obstetrics Clinics, 4 weeks Cardiology, 4 weeks Gastroenterology, 4 weeks Nephrology, 4 weeks Hematology, 4 weeks vacation, 4 weeks Diabetes, 8 weeks Internal Medicine, 4 weeks Intensive Care Unit, 4 weeks Dermatology, 4 weeks Oncology.



I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME Ralph C. Jung, M.D.
DIRECTOR OF MEDICAL EDUCATION

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS LAC/USC Medical Center
1200 North State Street, Box 540
Los Angeles, CA 90033

PHONE NUMBER (213) 226-6931

DATE June 23, 1989

SIGNATURE

L3

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA SEP 21 11 00 AM '90

90 SEP 21 PM 5:07 DIVISION OF LICENSING

CERTIFICATION STATEMENT

This is to certify that Kamran Torbati, M.D. (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on July 1, 19 89 and is expected to be completed on June 30, 19 93 in Obstetrics & Gynecology (Type of Training)

at Sinai Hospital (Name and Address of Facility)

6767 West Outer Drive, Detroit, MI 48235

(AFFIX SEAL OF)
(HOSPITAL OR)
(NOTARY PUBLIC)

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.

Marcia N. Persin, Associate Administrator, Clinical/Support Services

TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

Marcia N. Persin

SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

11/28/89

DATE

(313) 493-5075

PHONE NUMBER

07M-71 (3-87)

L9

PART 3

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? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I.☐ YES J.☒ NO

License Renewal Application
Physician and Surgeon

☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: K. Torbati MD DATE: 12.27.11

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 04/30/12
A 48821	03/31/12	$808.00	$886.00
	VOLUNTARY FEE =	$ —	$
	TOTAL ENCLOSED =	$ 808.00	$

ACTIVE KAMRAN TORBATI
5525 ETIWANDA AVE STE 216
TARZANA CA 91356

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( )

G. FINANCIAL INTEREST STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required here K. Torbati MD

OVER

6301010000010000200048821301033112000808000008860 0

01102012 28002255 28010033

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address
None	

SMBCLS 02/28/05

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?

____YES OR X NO

SUMMARY OF RENEWAL FEES OWED		FINANCIAL INTEREST STATEMENT	
		Health Facility Name	Address
		None	
2014 Renewal Fee	808.00		
Delinquent Fee			
Penalty Fee			
TOTAL FEES:	$808.00		

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

F._____ YES I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM.

H._____ YES I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM.

D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT:

I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE SECOND PAGE OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

Signature required K. Tadrati MD 25701

LICENSE NO. A 48821

EXPIRES 3/31/14

FEE OWED $ 808

DELINQ FEE IF POSTMARKED AFTER_____

$_____
$_____
$_____

TOTAL ENCLOSED

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET _____

CITY _____ STATE _____

ZIP _____

PHONE NUMBER (_____) _____

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required K. Tadrati MD

Dr. KAMRAN TORBATI
5525 ETIWANDA AVE STE 216
TARZANA, CA 91356

133364

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**48821**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**03/16/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**KAMRAN**
Last Name:	**TORBATI**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning:	**In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

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?	
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?	**Yes**

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.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 91356 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: 91356 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**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	**Middle Eastern**
Foreign Language Proficiency	**Hebrew**
	Persian (Farsi)
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**

Steven M. Thompson Physician Corps Loan Repayment Program	**$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:

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

18540394

Thank you for using the BreEZe System to submit your application.

Name:	TORBATI, KAMRAN
Transaction Date:	03/16/2016 15:54
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	48821
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	820.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.