STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

00343U

EDMUND G. BROWN JR., Gover

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
TELEPHONE:
Applications and Examinations (916) 322-3040

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

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

1991-00402

1. NAME: Last: Seletz First: Josepha Middle: Inez Maiden:
2. Telephone No. [redacted]
3. List other names, if any, you have used:
4. Address: Street and No./Rural Route [redacted] City [redacted] State [redacted] Zip Code [redacted]
5. Name you wish on License: Josepha I. Seletz Birthdate: (Month - Day - Year) [redacted]
6. Premedical Education: Name of College or University: University of California Location: Los Angeles
   Period of attendance: From: 9-1967 To: 6-1972
   Check premed courses successfully completed: ☑ Chemistry ☑ Physics ☐ Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	Temple University	Philadelphia, PA	9-1972	5-1976
2nd				
3rd				
4th				
5th				
6th				

8. Doctor of Medicine Degree granted by: ~~School of Med~~ Temple University ~~Medical School~~ Date: May 27 1976 For office use only School Code: PA 13
9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
San Francisco General Hospital	Rotating	June 1976	June 197

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? ☐ Yes ☐ No
    If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? ☐ Yes ☐ No
    If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

13. Are you now or have you ever been addicted to narcotic drugs? ☐ Yes ☐ No

14. Have you ever been convicted of, pled guilty or 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? Yes No

15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.) Yes No

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

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. Yes No

[redacted]

Applicant: Please complete the following:

Height: [redacted] Ft. [redacted] In. Weight [redacted] Lbs.

Hair color: [redacted] Eye color: [redacted]

Identifying marks: [redacted]

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 Josepha I. Seletz

Date Aug 8, 1977

Subscribed and sworn to before me this 8th day of August 1977

OFFICIAL SEAL
ADRIENNE R. WINAKUR
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires April 2, 1978

Signature of Notary Adrienne R. Winakur

Address 4867 Sunset Blvd.
Los Angeles 90027

My commission expires: April 2, 1978

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE: (916) 322-5040

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Joespha Inez Seltz
(Full name of applicant)

enrolled in Temple University Medical
(Name of medical school (college))

on the 11th day of September (Month) 19 72 (Year)

☒ 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:

☒ PHYSICS ☒ CHEMISTRY ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at University of California
(Please indicate school), and that he attended while at this medical school (college) four (Specify number) courses of lectures of 33 (Specify number of weeks) weeks each, completing n/a (Total hours) hours in the subjects below listed, and that he/she:

☒ was granted the degree { Bachelor / Doctor } of Medicine

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

_____

_____

on the 27 day of May (Month) 19 76 (Year)

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

*see attached sheet

_____ Anatomy	_____ Preventive medicine	_____ Medicine
_____ Embryology	_____ Hygiene and sanitation	_____ Pediatrics
_____ Histology	_____ Radiology, including roentgenologic technique and radiation safety	_____ Psychiatry
_____ Neuroanatomy	_____ Urology	_____ Neurology
_____ Physiology	_____ Ophthalmology	_____ Dermatology
_____ Psychobiology	_____ Anesthesia	_____ Physical medicine
_____ Biochemistry	_____ Otolaryngology	_____ Therapeutics
_____ Pathology, bacteriology and immunology	_____ Obstetrics and gynecology	_____ Tropical medicine
_____ Pharmacology		_____ Surgery, including orthopedic surgery

Signed and the College seal affixed this 22 day of July (Month) 1976 (Year)

[AFFIX SEAL HERE]

By Mrs. Janell M. Jones, Registrar
(President, Secretary, Dean)

07A-32 (REV. 2-75)

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 09/04/2010 **To Date:** 09/04/2010

ATRISUPPINF

01-JUL-11 13:46:31

Person Id : 587541 **Name :** Seletz,Josepha

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?	NO

Total Questions Asked For Person : 587541 8

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 09/08/2006 **To Date:** 09/08/2006

ATRISUPPINF

01-JUL-11 13:47:29

Person Id : 587541 **Name :** Seletz,Josepha

Question	Answer
I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	NO
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
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
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
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
I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES

Total Questions Asked For Person : 587541 7

PART 3

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

MEDICAL BOARD OF CALIFORNIA
LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

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 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: Josepha Seletz DATE: 8/13/18

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

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 10/30/08
$805.00	$885.50
VOLUNTARY FEE = $	$
TOTAL ENCLOSED = $	$

LICENSE NO. G 35414

EXPIRES 09/30/08

ACTIVE JOSEPHA INEZ SELETZ
10150 NATIONAL BLVD
LOS ANGELES CA 90034

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.

Josepha Seletz
Signature required here

63010700000700006000354142010930080008050000088550

002096 106 63010700006 000354142 080608
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

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.

19 805.00

Health-Related Facility Name	Address
NONE	

SMBCLS 02/28/05