



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

TELEPHONE

Applications and Examinations (916) 322-5040

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

PA-00402

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

RECEIVED
MAY 27 1976
STATE BOARD OF MEDICAL QUALITY ASSURANCE
SACRAMENTO, CALIFORNIA

1. NAME: Last <u>Seletz</u> First <u>Joseph</u> Middle <u>Inez</u> 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: <u>Joseph I. Seletz</u>				Birthdate: (Month - Day - Year) [REDACTED]	
6. Premedical Education: Name of College or University <u>University of California</u>				Location <u>Los Angeles</u>	
Period of attendance: From: <u>9-1967</u> To: <u>6-1972</u>		Check premed courses successfully completed: <input checked="" type="checkbox"/> Chemistry <input checked="" type="checkbox"/> Physics <input checked="" type="checkbox"/> Biology or Zoology			
7. Medical School:					
Year	Name of Institution	Location	From	To	
1st	<u>Temple University</u>	<u>Philadelphia, PA</u>	<u>9-1972</u>	<u>5-1976</u>	
2nd					
3rd					
4th					
5th					
6th					
8. Doctor of Medicine Degree granted by: <u>San Francisco Medical School</u>			Date <u>May 27 1976</u>	For office use only School Code: <u>PA-13</u>	
9. 1st Year Postgraduate Training (Internship):					
Location <u>San Francisco General Hospital</u>		Type of Service <u>Rotating</u>	From <u>June 1976</u>	To <u>June 1977</u>	
10. List all States in which you have been licensed to practice medicine: <u>none</u>					
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

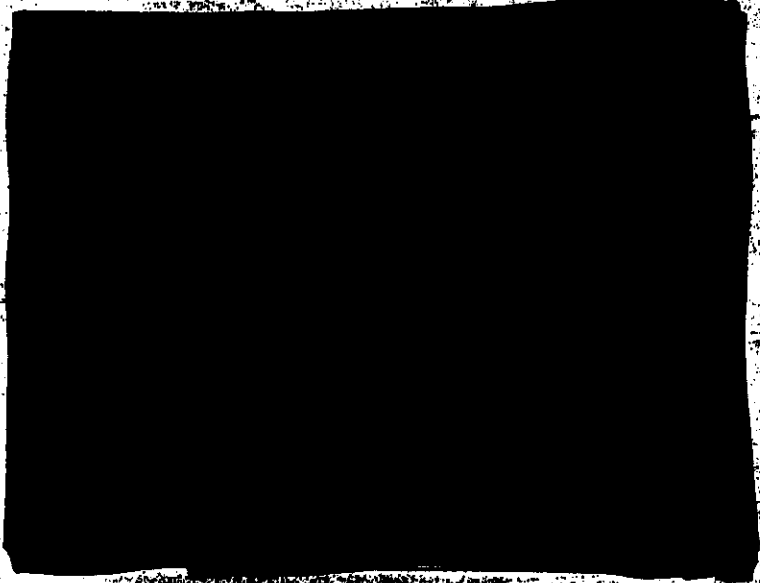
14. Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction? Yes No

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? Yes No
If yes, please explain on another sheet of paper.



Applicant: Please complete the following:

Height: Ft. in. Weight: Lbs.

Hair color: Eye color:

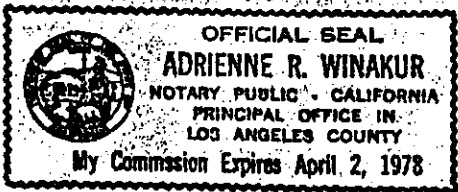
Identifying marks:

NOTE—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: Josephine J. Selaty
Date: Aug 8, 1977

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



Signature of Notary: Adrienne R. Winakur
Address: 4867 Sunset Blvd.
Los Angeles, 90027

My commission expires: April 2, 1978

**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

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**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

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**MEDICAL BOARD OF CALIFORNIA
LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON**



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

LICENSE NO. 35414 **EXPIRES** 09/30/08

VOLUNTARY FEE - \$
TOTAL ENCLOSED - \$

ACTIVE **JOSEPHA INEZ SELETZ**
10150 NATIONAL BLVD
LOS ANGELES CA 90034

AMOUNT DUE NOW **DELINQ FEE IF POSTMARKED AFTER 10/30/08**

\$805.00 \$885.50

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 ANY OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER WHICH WOULD EXEMPT ME FROM ANY OR PART OF THE REQUIREMENTS. DATE: 8/13/08

SIGNATURE REQUIRED HERE: *Joseph Inez Seletz*

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: *Joseph Inez Seletz*

