Maryland Board of Physicians Practitioner Profile System

This data was extracted on 07/20/2011

Seletz, Josepha Inez

License and Education		Primary Practice Setting	Public Address
License No.:	D60063	Josepha Seletz MD	10150 NATIONAL BLVD.
Accepts Medicaid:	No	10150 National Blvd	
Graduated:	1976		
License Status:	**Expired**	Los Angeles	LOS ANGELES
Date License Issued:	04/01/2003	CA 90034	CA 90034
License Expiration:	09/30/2007		

Graduated from: TEMPLE UNIV SCH OF MED

Known Disciplinary Actions by any state medical board (within the past 10 years)

Summary: No actions reported during the last ten year period.

Download all Maryland Disciplinary Actions

None

Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)

Malpractice Judgments and Arbitration Awards (within the past 10 years)

None Reported

Malpractice Settlements

(If there are 3 or more settlements of $150,000 or greater within the past 5 years)

None Reported

Convictions for any crime involving moral turpitude

None reported by the courts

Glossary of Terms

Notice to Credential Verification Professionals

Return to Practitioners Profile Search

Initial Medical Licensure
PERSONAL INFORMATION
1/2000

STATE OF MARYLAND
BOARD OF PHYSICIAN QUALITY ASSURANCE

4201 Patterson Avenue • P.O. Box 2571 • Baltimore, MD 21215-0095
Telephone: 410-764-4777 Fax: 410-358-2252 Toll Free: 800-492-6836

88619

APPLICATION FOR INITIAL MEDICAL LICENSURE

CR 206299

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

PAID #790

1. **Your Complete Legal Name** (Do not use nicknames or initials unless they are part of your legal name)

Last name and generational indicator (Jr., Sr., II, III, etc.)

Seletz, M.D.

First name and middle name:

Josepha Inez

Maiden name: (will not show on license)

Stop! If any credential you submit bears a name other than the name above, or if you have been licensed in another state under any name other than the name above, sign and date an attachment which in[redacted] and a copy of the legal document which supports the n[redacted]

2. **Public Address:** (Your address of record. This address, us[redacted]

Address: If you change your address prior to being licens[redacted]

10150 National Blvd.

City: Los Angeles State: CA Zip Code: 900034-

3. **Non-Public Address:** (Private address used only for official Board correspondence.)

Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.

[redacted]

City [redacted] State [redacted] Zip Code [redacted]

4. **Telephone (s):** Home [redacted] Office: [redacted]

Cell/Pager: [redacted] Fax: [redacted]

5. **Date of Birth:** Month: [redacted] Day: [redacted] Year: [redacted]

6. **Gender:** [redacted] Male [redacted] Female

7. **Race:** (Multiracial applicants may select all applicable categories) [redacted] American Indian or Alaska Native [redacted] Asian [redacted] Black or African American [redacted] Native Hawaiian or other Pacific Islander [redacted] White

Ethnicity: [redacted] Hispanic or Latino [redacted] Not Hispanic or Latino

8. **Social Security Number:** [redacted] **Federal Employer Identification Number:**

For Board Use Only													
	License Number: D60063	D	6	0	0	6	3	Control Number:	0	4	1	0	1	3
	Date Issued:	0	4	0	1	0	3	School Code:	0	3	9	0	8	0

Licensed By: _____ 6/02/04 How Licensed: NBME

9. Chronology of Activities (DO NOT ATTACH RESUME OR CURRICULUM VITAE.):

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended (whether or not you completed the program), each job you held (whether or not you were compensated), and any periods of unemployment.

Date Medical School was Completed:	month	year
	05	76

Subsequent dates: Please type or print clearly.

month	year	TO	month	year	Activity:
05	76	TO	06	76	*Preparing and waiting for Internship to begin*
					Address: *Relocating to California*
07	76	TO	06	77	**Activity:** *Rotating Internship / San Francisco General Hospital*
					Address: *1001 Petrero Ave. San Francisco, CA 94110*
07	77	TO	06	81	**Activity:** *Ob/Gyn Residency / Kaiser Permanente*
					Address: *4900 Sunset Blvd. Los Angeles, CA 90027*
07	81	TO	07	83	**Activity:** *Employed OB/GYN Kaiser Permanente*
					Address: *13652 Cantara Street Panorama City, CA 91402*
08	83	TO	Pres		**Activity:** *Private Practice+ IPA affiliation Cedars Sinai Medical Center*
					Address: *10150 National Blvd. Los Angeles, CA 90034*
		TO			**Activity:**
					Address:
		TO			**Activity:**
					Address:
		TO			**Activity:**
					Address:

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Chronology (Cont'd) Please photocopy this page if more space will be needed. Sign and date all additional pages and enclose them between pages 2 and 3 of the application.

month	year	TO	month	year	Activity:
					N/A
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:
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					Address:
					Activity:
					Address:
					Activity:
					Address:
					Activity:
					Address:

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Graduates of schools not in the U.S. or its territories, Canada, or Puerto Rico): If you did not receive this application directly from the Board of Physician Quality Assurance and have not completed the form FMS1, *Graduates of Foreign Medical Schools Request for Licensure Application*, please contact the Board at 410-764-4777 to request the form. DO NOT send your application or a check for fees until you have submitted form FMS1 to the Board and received a reply.

10. **MEDICAL EDUCATION: List all medical schools you have attended** — From: MM/YY To MM/YY

Temple University School of Medicine	*09/72* *05/76*

Medical School From Which You Received Your Medical Degree: *Temple University School of Medicine*

Name of University Affiliation (if applicable): * *N/A*

Street Address: *3400 N. Broad Street*

City: *Philadelphia* **State/Province:** *Pennsylvania*

Country: *USA* **Country of citizenship during medical education** *USA*

Language(s) of Instruction: *English*

Type of Degree: ☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

Date Degree Was Conferred: (The date you officially received your degree after all prerequisite obligations [required training, government service, etc.] were satisfied.) Month: 0 5 Year: 7 6

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Graduates of schools not in the U.S. or its territories, Canada, or Puerto Rico): **Attach the following documents to this application: 1) A copy of your valid ECFMG certificate or Fifth Pathway Certificate; 2) A copy of your medical school diploma and a certified translation; 3) If you listed an affiliation above (see * in 11 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate (the certificate must show your name, name of the medical school, and name of the university), and a certified translation.**

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See the document *English Language Competency Requirements* that is included in your application packet.)

a. ☐ Graduation from a professional school or, after at least three years of attendance, a high school (includes GED), undergraduate college or university where English was the language of instruction throughout. You must provide documentation.

b. ☐ TOEFL or ☐ ECFMG English test taken beginning January, 1974 **AND** ☐ TSE or ☐ OPI
(If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request the administering authority to send verification directly to the Board of Physician Quality Assurance.)

Are you claiming speech impairment? ☐ NO ☐ YES (If "YES," please write or call the Board for additional information.)

Stop! Following this page you will find Form BPQA IML2, *Verification of Education and English Language Instruction.* Complete Part 1 of form IML2 and send it to the institution from which you received your medical degree and (if it is different) a copy to the institution at which you satisfied Maryland's English language competency requirements. Please instruct the institution(s) to mail the completed IML2 directly to the Board in an envelope that clearly bears the institution's name and address. Forms not received directly from the institution will not be accepted.

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the United States, Canada, or Puerto Rico whether it was completed or not and whether it was compensated or not. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may allow the substitution of one year of **full time teaching in an LCME -accredited medical school in the United States** for one year of an accredited training program, up to a maximum of two years. Applicants who intend to substitute teaching experience for postgraduate training should contact the Board's licensure division for further information.

=> => Graduates of medical schools accredited by the Liaison Committee on Medical Education or the American Osteopathic Association at the time of their graduation must have successfully completed 12 continuous months of ACGME/AOA-accredited clinical postgraduate training. Graduates with medical degrees conferred on or after July 1, 1992, from medical schools in any country other than the United States Canada, or Puerto Rico must have obtained ECFMG certification and have successfully completed three years of ACGME-accredited clinical post-graduate training. If you have not successfully completed the required years of training, DO NOT submit this application.

=> => A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME-accredited training *after* successfully completing a Board-approved Fifth Pathway program. If you have not met these two criteria, DO NOT submit this application.

=> => If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) which at any time you had failed three or more times, you must successfully complete another year of ACGME-accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. The additional year must have begun after the date of the last fail. If you have not met this requirement, DO NOT submit this application.

PG Years 1	Place of Training:	*San Francisco General Hospital*					month 0 7	year 7 6	TO	month 0 6	year 7 7
	Address: *1001 Petrero Ave. San Francisco, CA 94110*		Specialty: *Rotating Internship*				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				
PG Years 2	Place of Training:	*Kaiser Permanente Medical Center*					month 0 7	year 7 7	TO	month 0 6	year 7 8
	Address: *4900 Sunset Blvd. Los Angeles, CA 90027*		Specialty: *Ob/Gyn Residency*				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				
PG Years 3	Place of Training:	*Kaiser Permanente Medical Center*					month 0 7	year 7 8	TO	month 0 6	year 7 9
	Address: *4900 Sunset Blvd. Los Angeles, CA 90027*		Specialty: *Ob/Gyn Residency*				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				
PG Years 4	Place of Training:	*Kaiser Permanente Medical Center*					month 0 7	year 7 9	TO	month 0 6	year 8 0
	Address: *4900 Sunset Blvd. Los Angeles, CA 90027*		Specialty: *Ob/Gyn Residency*				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				
PG Years 5	Place of Training:	*Kaiser Permanente Medical Center*					month 0 7	year 8 0	TO	month 0 6	year 8 1
	Address: *4900 Sunset Blvd. Los Angeles, CA 90027*		Specialty: *Ob/Gyn Residency*				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				
PG Years	Place of Training:						month	year	TO	month	year
	Address:		Specialty:				Accredited by: ACGME ☐ AOA ☐ RCPSC ☐				

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

STOP! **Following page 6 you will find Form BPQA IML3, *Verification of Postgraduate Medical Education.* For each of the programs you have listed above, complete Part I of the IML3 and send a *copy of the IML3 to the Program Director. Be certain to contact all programs before you send your request. Many programs now charge a fee for verification of training. All fees are the responsibility of the applicant.**

* Please remember to copy both sides of Form IML3 before sending it to the Program Director.

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals at which you have had privileges or have provided services since the completion of your postgraduate training and during the five year period preceding the filing of this application. Copy this page first if more space will be needed and enclose each signed and dated addition between pages 6 and 7.

Hospital: *Cedars Sinai Medical Center*	month *0 8* year *8 3* TO month *P r* year *e s*
Complete Address: *8700 Beverly Blvd. Los Angeles, CA 90048-1865*	**Department** *Attending OB/GYN Physician*
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**
Hospital:	month year TO month year
Complete Address:	**Department**

STOP! **Remember that following this page you will find BPQA Form IML3, *Verification of Postgraduate Medical Education.* For each of the postgraduate medical education programs listed on page 5, complete Part I of the IML3 and send a *copy of the IML3 to the Program Director. Be certain to contact all programs before you send your request. Many programs now charge a fee for verification training. All fees are the responsibility of the applicant.**

***Please remember to copy both sides of Form IML3 before sending it to the Program Director.**

14. Medical Licensing Examinations

Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO [redacted] YES [redacted] Since October 1, 1992, have you passed any medical licensing examination (or part, step, or component thereof) which at any time you had failed three or more times? NO [redacted] YES [redacted]

If you answered "Yes" to this question, you must have successfully completed another year of ACGME-accredited postgraduate training in addition to the number of years of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. ☐ **State Board Examination(s)** _____
State(s) Which Administered the Examination(s)

NOTE: **State Board examinations taken after December 31, 1984 are not accepted for licensure in Maryland.**

Following page 8, you will find supplemental form BPQA IML7, *State Board Licensure and Examination Certification.* Send a copy of this form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Board of Physician Quality Assurance. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML5. All fees are the responsibility of the applicant.**

Federation of State Medical Boards

b. ☐ FLEX-Weighted Average } **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days) unless you are currently certified by a member of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2 } **Examinations must be passed within 5 years of each other.**

d. ☐ USMLE Steps 1, 2, and 3 } **Passing scores on all parts must have been completed within a 7-year period (10 years for MD/PhD) beginning with the month and year when the examinee first passes either Step 1 or Step 2.**

Immediately following this application, you will find the form entitled *Request for Examination and Board Action History Report* ("EBAHR"). Complete the form and mail it in the enclosed, pre-addressed envelope to the Federation of State Medical Boards. Be certain to include your check and request for the transcripts to be sent directly to the Board of Physician Quality Assurance.

e. ☒ **National Board of Medical Examiners**

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org/new.version/cert.form.htm.** If you took NBME exams but were not certified, or took NBME as part of hybrid exams, ask NBME to send only your Record of Scores. If you have difficulty accessing the web site, call 215-590-9500 for instructions.

f. ☐ **National Board of Osteopathic Medical Examiners** } **Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.**

If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

Medical Council of Canada

g. ☐ Licentiate of the Medical Council of Canada

Please request that verification of your licenciate certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 7-year period (10 years for graduates of MD/PhD programs) beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org/new.version/cert.form.htm** and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Board of Physician Quality Assurance.
- If your hybrid exams included only FLEX and USMLE examinations, complete the form entitled *Request for Examination and Board Action History Report* ("EBAHR") which follows this application and send it with your fees to the Federation of State Medical Boards.

15. Licensing History

Please list all licenses ever issued to you by a U.S. state or territory or Puerto Rico, and all Canadian licenses and registrations.

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b.

STATE / PROVINCE	LICENSE / REGISTRATION NUMBER	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Suspended	Revoked	Surrendered in good standing
California	*G35414*	✓		4-1-03 SEE PHYSICIANS 3/24/03 LETTER WITH NEWLY ISSUED LICENSES PER MERLE GOLDMAN, CHIEF OF LICENSURE, DON'T NEED TO REQUIRE VERIFICATION OF NEW LICENSES. bfa			

(If more space is needed, please attach an additional signed and dated sheet.)

c. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

Stop! Following this page you will find form BPQA IML7. Complete Part 1 of form IML7 and send a copy to each medical board in the U.S., its possessions and territories, Puerto Rico, and Canada that ever issued you a license/registration or administered to you a state/provincial licensing examination. Please check with each board first to determine if a fee is charged for your verification. The addresses and telephone numbers of all U.S. state medical boards can be found on the Federation of State Medical Board internet site at www.fsmb.org.

16. **Special Purpose Examination ("SPEX"):** Check either YES or NO.

YES	NO	
[redacted]	[redacted]	Did you successfully complete your medical licensing examination within the 15 year period prior to filing this application?
[redacted]	[redacted]	Have you had an active license in the U.S., its territories, Puerto Rico, or Canada at all times during the past ten years?
[redacted]	[redacted]	Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada? If "YES," in which specialty were you certified? _____ Date certified _____

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you send your application, contact the Federation of State Medical Boards at 817-571-2949 and tell them you are required to take the SPEX in Maryland. Please make arrangements for your scores to be sent to the Maryland Board.**

17.

YES	NO	Character and Fitness (Check either YES or NO)
a. [redacted]		Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b. [redacted]		Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license ? (Such actions include, but are not limited to, limitations of practice, required education, admonishment, reprimand, suspension or revocation.) [Refer to the document *Grounds for Board Action in Maryland* included with your application packet.]
c. [redacted]		Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d. [redacted]		Have you ever withdrawn your application for a medical license or other health professional license ?
e. [redacted]		Has a hospital, a related health care institution, or an alternative health care system investigated you or brought charges against you ?
f. [redacted]		Has a hospital, a related health care facility, or an alternative health care system denied your application for, failed to renew, limited, restricted, suspended, revoked, or taken away your privileges
g. [redacted]		Have you commited a criminal act to which you plead guilty or nolo contendere or for which you were convicted or received probation before judgement?
h. [redacted]		Have you committed an offense involving alcohol or controlled dangerous substances to which you plead guilty or nolo contendere or for which you were convicted or received probation before judgement? (Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.)
i. [redacted]		Excluding minor traffic violations, are you currently under arrest, released on bond, or are there any current or pending charges against you in any court of law?
j. [redacted]		Do you illegally use drugs?
k. [redacted]		Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l. [redacted]		Within the past five years, has anyone filed or settled a medical malpractice action in which you were named as a defendant?
m. [redacted]		Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n. [redacted]		Have you failed to make arrangements to satisfy State or federal loans that financed your medical education?
o. [redacted]		Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p. [redacted]		Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution?
q. [redacted]		Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
r. [redacted]		Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**

18. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all supporting documentation. Attach additional signed and dated pages as needed.

Number of malpractice claims ever filed against you [redacted] Number of malpractice claims filed against you within the last 5 years [redacted]

Number of claims paid within the last 5 years 1) as a result of judgment [redacted] 2) prior to judgment [redacted]

N/A

I have attached the following number of pages to this application: *0*

19. CHECKLIST

Please review the checklist before signing page 12. A few minutes spent in review now may save days or weeks of delay in the processing your application.

Control No:88619 10/02/2002 09:06
Seletz, Josepha Inez
Application Form (Standard)
Received: Dierdra Partlow
Analyst: Kevin Melville

☒ I have provided all the personal information requested on this appl

☒ My chronology is legible and there are no gaps in time. (pages 2 a

☐ (If applicable) I have enclosed additional sheets for my chronology

☒ I have provided all the information about my medical degree and requested verification from my medical school (page 4 and IML2)

☐ I have requested that my medical school send documentation of my English proficiency to the Board (Form IML2, follows 4)

Foreign Medical School Graduates

☐ My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board.

I have enclosed the following documents:

☐ A copy of my valid ECFMG certificate.

☐ A copy of my medical school diploma and a certified translation.

☐ (If applicable) A copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

☒ I have completed Part 1 of form IML2 and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.

☒ I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3 and printed my name on side B; and have sent a copy of form IML3 to the director of each program in which I participated.

☒ I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6).

☒ I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).

☒ I have listed every license I have ever been issued (page 8) and have sent a copy of IML7 to each medical board that issued me a license in the U.S., its territories, Puerto Rico, or Canada.

☒ I do not have to take the Special Purpose Exam (page 9) ☐ I must take the SPEX and have made arrangements to do so.

☒ I have answered all character and fitness questions (page 9), explained all "yes" answers, and enclosed all supporting documents that apply (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)

☒ I have attached a 2"x 2" passport quality photograph to the last page (page 12) of this application.

☒ I have read the statements on page 12 of this application; initialed my agreement; signed and dated the application; and arranged to have the application notarized.

☒ I have enclosed my check made out to "Board of Physician Quality Assurance" (or "BPQA") in the amount of either $790.00 (Graduates of LCME-accredited American and Canadian medical schools) or $890.00 (Graduates of International Medical Schools).

☐ (If applicable) I have enclosed the Applicant's Preferred Date of Licensure form that was in my licensure packet.

☒ I have stamped the pre-addressed envelope provided by the Board for the return of my application.

☒ I have attached the following number of pages of documentation to support this application: 0

STOP! This is not the last page of your application. Please complete page 12 and have it notarized.

Initial Medical Licensure Release and Certification 1/2000

RELEASE AND CERTIFICATION

20. Release:
I agree that the Board of Physician Quality Assurance ("Board") may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Josepha I Seletz — Signature — 8/25/02 — Date:

21. (OPTIONAL) Third Party Release: (Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.)

I agree that the Board of Physician Quality Assurance may release any information pertaining to the status of my application to the following person:

Name: *Lois Cole @ Physician Licensing Service*

Phone: *801-951-3300 ext 203*

Josepha I Seletz — Applicant's signature — 8/25/02 — Date

22. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address, or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Josepha I Seletz — Signature — 8/25/02 — Date

23. Affidavit: (To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.)

I certify that I personally have reviewed all the responses to items 1-23 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Josepha I Seletz — Applicant's signature — 8/25/02 — Date

STATE OF California

CITY/COUNTY OF Los Angeles

I HEREBY CERTIFY that on this 25 day of August, 20 02, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Josepha Ines Seletz (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Klamaria A. Grogan — Notary Public

My Commission expires: May 3, 2005

SEAL
KLAMARIA A. GROGAN
Commission # 1299809
Notary Public - California
Los Angeles County
My Comm. Expires May 3, 2005

Initial Medical Licensure
Supplemental Form
BPQA IML7
7/2001

MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE
4201 Patterson Avenue · P.O.Box 2571
Baltimore, Maryland 21215-0095

Follows page 8 of the application

STATE BOARD LICENSURE AND EXAMINATION CERTIFICATION

Part 1 APPLICANT: Complete Part 1 and send a copy of this form to each medical board in the U.S., its possessions or territories, Puerto Rico, and Canada that ever issued you a license or administered to you a state/provincial licensing examination.

1. *New Jersey State Board* — State of Licensure
2. _____ — License Number
3. *09/26/1950* — Date of Birth
4. *Seletz, M.D.* — Last Name under which You Were Licensed; *Josepha* — First Name; _____ — Middle Name
5. _____ — Current Name if Different from Above; First Name; Middle Name
6. *10150 National Blvd.* — Current Street Address; *Los Angeles* — City; *Ca 90034* — State
7. Social Security Number: [redacted]
8. Telephone Number: [redacted]
9. *See Authorization* — Signature; *04/07/03* — Date:

Part 2 AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Board of Physician Quality Assurance at the above address.

1. MA75564 — License Number
2. 3-19-03 — Date of Original Licensure
3. 6-30-03 — Date License Expires/Expired

4. Is the license in good standing or, if expired, was the license in good standing at the time of expiration? [redacted] Yes [redacted] No

5. Is there, or has there ever been, derogatory information, pending charges, or disciplinary action taken against this license? [redacted] Yes [redacted] No

If "Yes": [redacted] Pending charges [redacted] reprimanded [redacted] suspended [redacted] revoked [redacted] surrendered [redacted] terms/condition/probation

==> On the back of this form, or as an attachment, please explain any derogatory information and include all available documentation.

6. Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? [redacted] Yes [redacted] No

7. Was the applicant licensed in your state based on an examination administered by your state rather than an examination administered by the Federation of State Medical Boards, the National Board of Medical Examiners, or the National Board of Osteopathic Medical Examiners? [redacted] Yes [redacted] No

If the answer to question 7 was "Yes", please attach an official copy of the exam results.

LICENSE IN GOOD STANDING
NO DEROGATORY INFORMATION

Printed name of Authorized Official

Title of Authorized Official

William V. Rohde, Exec. Dir.

Signature of Authorized Official

Direct Telephone Number

Printed Name of State

APR 25 2003

Date

State Board Seal

PRINT RETURN

BOARD OF PHYSICIANS
P.O. Box 17314
Baltimore, Maryland 21297-0475
Application for Renewal of Medical License
(410) 764-4705

1. MEDICAL LICENSE NUMBER	**D0060063**
2. NAME	**Dr. Josepha Inez Seletz**
Date Completed	**9/24/2005**

Email: [redacted]

ADDRESS CHANGES
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of **July 1, 2005**. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.
3a. Non-Public Mailing Address: This address is for Board use only and is where your license will be mailed. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City [redacted]
State/Province [redacted]
Zip Code [redacted]
Country [redacted]

3b. Public Mailing Address: This address, usually your office, is available to the public and **will** be posted on the Internet. **If you do not designate a public address, your non-public address will be posted on the Internet.**

Organization Name
Street 10150 NATIONAL BLVD.
Street (2)
Street (3)
City LOS ANGELES
State/Province California
Zip Code 90034
Country United States

PERSONAL AND PROFESSIONAL INFORMATION
4. Do you give the Maryland Board of Physicians permission to report my date of birth to the Federation of State Medical Boards' Physician Data Center?
See instruction

Yes No

5a. Are you engaged in the direct care of patients in the State of Maryland? Answer yes if you saw one or more patients within

the period since July 1, 2003 or initial licensure or reinstatement in Maryland whichever is more recent. *

Yes No

5b. If you answered **NO** to the previous question, did your practice include making decisions that had direct impact on patient care in Maryland (such as radiology, pathology, or medical director)? Yes No

CHARACTER AND FITNESS QUESTIONS

6. The following questions pertain to the period since July 1, 2003. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement.

Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.
* All questions must be answered Yes or No.

QUESTION

[redacted]a Yes No Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]b Yes No Have any complaints, investigations or charges been brought against you, or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

[redacted]c Yes No Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]d Yes No Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]e Yes No Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]f Yes No Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

[redacted]g yes No Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

[redacted]h Yes No Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

[redacted]i Yes No Do you have a physical or mental condition that currently impairs your ability to practice medicine?

[redacted]j Yes No Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

[redacted]k Yes No Do you illegally use drug(s)?

[redacted] l Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
Yes No

[redacted] m Have you been named as a defendant in a filing or settlement of a medical malpractice action?
Yes No

[redacted]

[redacted] n Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any disciplinary reasons?
Yes No

[redacted] o Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
Yes No

[redacted] p Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?
Yes No

[redacted] q Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?
Yes No

CONTINUING MEDICAL EDUCATION

- You must complete this form for your license to be renewed. Choose one statement that applies to you.

7. Choose one statement that applies to you.

CME met. I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2003 or reinstated, you are not required to take the NPO.See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Part 2)

8. Ethnicity and Race: (Select all that apply)

[redacted] Hispanic or Latino
American Indian or Alaska native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other

9. Are you employed by the Federal Government? [redacted] Yes [redacted] No

10. Do you plan on ending your medical practice in the next 2 years? [redacted] Yes [redacted] No Not Applicable

11. Do you plan to leave Maryland in the next 2 years? *
Yes No Military Unknown Not Applicable

12. Which best describes your current area(s) of concentration:

Primary Concentration * Obstetrics & Gynecology (General)

Secondary Concentration None

13. List up to two (2) specialty areas **only** if certified by a recognized board of the American Board of Medical Specialties or the American Osteopathic Association and provide the year of your certification or recertification. **(If you select a Primary or Secondary Specialty, the year of your certification or recertification is required.)**

Primary Specialty Obstetrics & Gynecology (General) Year 1983 (yyyy)

Secondary Specialty None Year (yyyy)

HEALTH CLAIMS ARBITRATION OFFICE QUESTIONS

14. The following questions pertain to the period since July 1, 2003. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement.
Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.
* All questions must be answered Yes or No.

		QUESTION
[redacted] Yes	No	a Have you been the subject of professional discipline?
[redacted] Yes	No	b Have you, your partners or associates, or anyone in your immediate family or household, been sued or had a claim filed against you or any of them for medical malpractice?
[redacted]		
Yes	No	c Have you testified as a medical witness in a judicial or administrative proceeding?
Yes	No	d Have you been an arbitrator?
Yes	No	e Are you currently an arbitrator?
Yes	No	f Are you, or any member of your immediate family or household, currently a party in a medical malpractice case?
Yes	No	g Is there any reason why you could not hear and decide impartially a health care malpractice claim solely on the basis of the law and the evidence presented?

PRACTICE INFORMATION

15. Do you currently practice medicine?

Yes No

16. If you are not in practice, are you:

1. Retired, permanently not in practice
2. Semi-Retired, working outside of the practice of medicine
3. Temporarily not in practice
4. Inactive for other reasons
5. Working full-time outside the practice of medicine

17. What percent of your average work day is spent in personally providing PRIMARY/PREVENTIVE CARE SERVICES in Maryland? 0 %

18. If all offices are located outside Maryland, do you treat Maryland residents? Yes No Not Applicable

19. What is the total number of practice/office locations at which you personally work within Maryland? 0

20. Primary Practice / Office Location

Organization Name	Josepha Seletz MD
Street Address	10150 National Blvd
Street2	
City	Los Angeles
State	California
Zip Code	90034
Office Phone	[redacted]
Office Fax	[redacted]
Jurisdiction	Non-Maryland
Employer Tax ID	[redacted]

At this site, what is the average number of hours per week you are available for ALL PATIENT CARE? 40 * (if None, enter 0)

Setting	Freestanding Physician Office
Practice	Solo
Primary Role	Clinical/Direct Patient Care
Secondary Role	None
Private/Public	For profit

21. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients.

In your practice, are computers or other forms of information technology used:

A. To obtain information about treatment alternatives or recommended guidelines?
Yes No

B To send prescriptions electronically to a pharmacy?
Yes No

If you answered **yes** to 21B, what percentage of prescriptions are submitted electronically? %
(Please enter a whole number for the percentage. No decimals)

C. To generate reminders for you about preventive services needed for your patients?
Yes No

D. To access patient notes, medication lists, or problem lists?
Yes No

E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?
Yes No

F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?
Yes No

G. To communicate about clinical issues with patients by email?
Yes No

H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?
Yes No

I. If you admit patients to the hospital, does the hospital where most of your patients are treated have computerized systems to order tests and medications? Yes No Not Applicable

22. Secondary Practice / Office Location

Organization Name

Street Address

Street2

City

State

Zip Code

Office Phone

Office Fax

Jurisdiction

Employer Tax ID

At this site, what is the average number of hours per week you are available for ALL PATIENT CARE? 0 * (if None, enter 0)

Setting

Practice

Primary Role

Secondary Role

Private/Public

23. Do you participate in the Maryland Medical Assistance (Medicaid) program? Yes No Not Applicable

24. If YES to question 23, enter the Maryland Medical Assistance Rendering Provider Number:

25. If YES to question 23, are you accepting new Maryland Medical Assistance patients? Yes No

26. Do you participate in Medicare? Yes No Not Applicable

27. If YES to question 26, enter the Individual Medicare UPIN

28. If YES to question 26, are you accepting new Medicare patients? Yes No

29. Do you offer a sliding fee scale based on ability to pay?
(Utilize a standardized fee reduction schedule for low-income) Yes No Not Applicable

30. Do you offer uncompensated (charity) care? Yes No Not Applicable

31. If YES to question 30, report the number of hours you personally provide in uncompensated care in a month: 4

32. Is a Physician Assistant, Nurse Practitioner, or Nurse Midwife included as part of your practice (employee or on staff)?
Yes No

33. Worker's Compensation

Workers' Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I certify one of the following: Not Applicable (Do not complete below)

I do not practice in Maryland.

I do not employ anyone in my practice in Maryland.

I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage.

Name of Insurance Carrier

Policy Number

Expiration Date

PHYSICIAN EMERGENCY CONTACT INFORMATION

As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Catastrophic Health Emergencies Act Md. Code. Ann., Article 41 Sec. 2-201-204 and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.)

If you work for the Federal government or military and you would not be available to volunteer, please check YES to the question below--you will not be required to complete the volunteer contact information.

● Yes ○ No Do you work for the Federal government or the military and **would not** be available to volunteer ?

If you answered No , please provide (or update) the following information that should be used in the event of an actual emergency. ***Otherwise, please press Enter and your contact information will be erased.***

Pager

Cell Phone [redacted]

Home Telephone

Fax

Email [redacted]

Work Telephone [redacted]

Fax [redacted]

Email [redacted]

Name of Practice [redacted]

County Non-Maryland

City Los Angeles

State California

Zip [redacted]

Please provide (or update) the one best number that should be used in the event of an actual emergency.

Daytime: [redacted]

Nighttime: [redacted]

Preference Area:
Indicate which counties you would prefer to work in the case of an actual emergency.

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

☐ Check here if you are interested in being contacted about training opportunities provided by the Board of Physicians.

Thank you for your assistance !

34. AFFIRMATION OF RENEWAL APPLICATION AND PAYMENT

- You have completed all the question sections in the application.

- You must affirm your answers on the application before you can pay your license renewal fee.
- **You will not be allowed to change any answers once you affirm your answers.**
- You may wish to recheck your answers by returning to the Menu before you affirm.
- You also have the option of viewing your renewal application online anytime after completion. **To exercise this option, you must select the option box below.**
- Once you affirm, select a Payment option.

Affirmation and Authorization

(Please check each box to affirm the following questions)

I affirm that the information I have given in this application, including that given to Character and Fitness questions (a) through (q), is true and correct to the best of my knowledge and belief.

I authorize any person(s) to release to the Maryland Board of Physicians any information or documents needed pertaining to my application for licensure.

I shall inform the Board, by certified mail, return receipt requested, within 30 days of:

(a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period;

(b) change in any answer that was originally given in this application.

Check Here if you wish to have the option of viewing your completed application online ***after*** you renew your license. Otherwise, your application will not be available online for your later viewing.

Maryland Board of Physicians
P.O. Box 2571 Baltimore, Maryland 21215-0095
Help Line (410)764-4705
Main (800) 492-6836 Fax (410)358-2252
1-800-735-2258 TTD for Disabled
Email mbp@erols.com

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