MEDICAL BOARD OF CALIFORNIA
LICENSE LOOKUP SYSTEM

License Information:

The following information is maintained by the Medical Board of California. For more information, click on the blue tabs above.

License:	**A 91809** Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the FLEX (Federation Licensing Exam), USMLE (United States Medical Licensing Exam) or LMCC (Licentiate of Medical Council of Canada) written examination and has been licensed less than four years in another state OR may be an International medical school graduate whose pathway to licensure was based on the above exams or approved combinations of the NBME (National Board Medical Exam), FLEX or USMLE.
License Type:	Physician and Surgeon
Name:	VIKRAM S KOTHANDARAMAN, M.D.
Address of Record:	**315 ELLINGBROOK DR** **MONTEBELLO, CA 90640**
Address of Record County:	LOS ANGELES
License Status:	**License Renewed & Current** Licensee meets requirements for the practice of medicine in California.
Public Record Action(s):	No Public Record Actions available
Original Issue Date:	June 22, 2005
Expiration Date:	February 28, 2013
School Name:	UNIVERSITY OF MADRAS, CHINGLEPUT MEDICAL COLLEGE
Year Graduated:	1995

Physician Information:

The following information is self-reported by the licensee and has not been verified by the Board.

Activities In Medicine:	PATIENT CARE - 30 TO 39 HOURS RESEARCH - 1 TO 9 HOURS ADMINISTRATION - 1 TO 9 HOURS OTHER - 1 TO 9 HOURS
Primary Practice Location Zip Code:	90033
Board Certification(s):	No board certifications identified
Primary Practice Area(s):	OBSTETRICS & GYNECOLOGY
Secondary Practice Area(s):	No secondary practice areas identified
Post Graduate Training Years:	4 YEARS
Ethnic Background:	Declined to Disclose
Foreign Language(s):	Declined to Disclose
Gender:	Declined to Disclose

Public Record Action(s):

Please select the Public Record Documents tab to view the public document database. If information is posted in the Administrative Disciplinary Actions, Court Order, Administrative Citation Issued, or License Issued with Public Letter of Reprimand categories below, documents may be available for review. To find out what information is and is not available, please click here.

Administrative Disciplinary Actions:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

No Administrative Disciplinary Actions found.

Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of the public documents.

No Court Orders found.

Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

No Administrative Actions Taken by Other State or Federal Government found.

Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

No Felony Convictions found.

Misdemeanor Conviction:

California Business and Professions Code section 2027 (A)(7) states effective 1/1/07, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet. To see if a conviction has been expunged or dismissed, please contact the court below.

No Misdemeanor Convictions found.

Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

No Administrative Citations found.

License Issued with Public Letter of Reprimand:

The Medical Board of California has concurrently issued the applicant a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

No License Issued with Public Letter of Reprimand found.

Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide health care services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

No Hospital Disciplinary Actions found.

Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

No Malpractice Judgments found.

Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the arbitration award report or any other information concerning the award.

No Arbitration Awards found.

Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of $30,000 or more.

No Malpractice Settlements found.

Note: "No information available from this agency" may not indicate none exists; but indicates no information has been reported to the Medical Board of California and/or that the Board is unable to post the information on the Web site by law.

Public Record Documents:

All imaged documents provided by the Medical Board are being made available to provide immediate access for the convenience of interested persons. While the Medical Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Medical Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. The Medical Board shall not be responsible for any errors or omissions, or for the use or results obtained from the use of this information. The types of documents which are available include, but are not limited to, accusations, decisions, suspension/restriction orders, public letters of reprimand and citations.

No documents found.

Please note that documents with an effective date prior to calendar year 2000 may not be available via the Web. To obtain a copy of the documents not posted on this site, please contact the Central File Room at (916) 263-2525 or click here for information on ordering public documents.

Disclaimer

All information provided by the Medical Board of California on this Web page, and on its other Web pages and Internet sites, is made available to provide immediate access for the convenience of interested persons. While the Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. Neither the Board, nor any of the sources of the information, shall be responsible for any errors or omissions, or for the use or results obtained from the use of this information. Other specific cautionary notices may be included on other Web pages maintained by the Board. All access to and use of this Web page and any other Web page or Internet site of the Board is governed by the Disclaimers and Conditions for

Access and Use as set forth at California Department of Consumer Affairs' Disclaimer Information and Use Information.

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

APPLICATION UPDATE FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

1. NAME: Last	First	Middle	MBC USE ONLY
KOTHANDARAMAN	VIKRAM	S.	Personal Data

2. Other names you have used (include maiden name):	3. U.S. Social Security Number*	
K. MURUGAN	[redacted]	☐

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.				
				☐
City	State	Zip Code	Country	☐

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]				
				☐
City [redacted]	State [redacted]	Zip Code [redacted]	Country U.S.A	☐

5. Telephone Number: Home: [redacted] Work:	6. California Driver's License Number (optional): NUMBER	EXPIRATION	☐
7. Date of Birth (Month/Day/Year) and Place of Birth: [redacted]	8. Sex: ☐ Male ☐ Female		☐

9. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No — License Data ☐

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	LGS
				☐
				☐
				☐
				☐

10. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No — Other Professional Licenses ☐

IF YES; PROFESSION: _____, LICENSE NO.: _____, JURISDICTION: _____.

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

☒ Yes ☒ No ☐

11A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) — Postgraduate Training

☒ Yes ☐ No ☐

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorical Specialty Area	Dates of Attendance	
NY MEDICAL COLLEGE	Jamaica, NY	OB/GYN PGY-4	07/2004 - 06/2005	☐
NY MEDICAL COLLEGE	Jamaica, NY	OB/GYN PGY-3	07/2002 - 06/2003	☐

QUESTIONS 11B through 18B:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

11B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

☒ Yes ☒ No ☐

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

12. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgment, or arbitration award of over $30,000.00?

☒ Yes ☒ No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY — School Code

L8A

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental agency.

MBC USE ONLY

License Data

13A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

13B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

13C. Is any such action as described above pending?

13 (A) [redacted] Yes [redacted] No ☐

13 (B) [redacted] Yes [redacted] No ☑

13 (C) [redacted] Yes [redacted] No ☐

IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

14. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

[redacted] Yes [redacted] No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

15. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

[redacted] Yes [redacted] No ☑

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

16. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

[redacted] Yes [redacted] No ☑

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

17. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

[redacted] Yes [redacted] No ☑

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

18A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

18B. Is any criminal action related to the above pending?

18 (A) [redacted] Yes [redacted] No ☐

18 (B) [redacted] Yes [redacted] No ☐

IF YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Applicant Declaration/Signature and NOTARY

STATE OF [redacted]

COUNTY OF [redacted]

The applicant, [redacted] (PLEASE PRINT FULL NAME) [redacted] (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT THERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGNATURE OF APPLICANT: [redacted] (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 15 day of March (MONTH) 2005 (YEAR).

NOTARY SEAL

[redacted]
SIGNATURE OF NOTARY PUBLIC

[redacted]
ADDRESS

My commission expires August 21, 2006.

L8B

DEBRA COHEN
NOTARY PUBLIC - STATE OF NEW YORK
NO. 01CO6064761
QUALIFIED IN NASSAU COUNTY
MY COMMISSION EXPIRES AUG. 21, 2006

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

12-31

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY

1. NAME: Last: KOTHANDARAMAN | First: VIKRAM | Middle: S — *Personal Data*

2. Other names you have used (include maiden name): K. MURUGAN

3. U.S. Social Security Number* [redacted]

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. [redacted]

City [redacted] State [redacted] Zip Code [redacted] Country: U.S.A

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.] [redacted]

City [redacted] State [redacted] Zip Code [redacted] Country: U.S.A

5. Telephone Number:
Home: [redacted]
Work: [redacted]

6. California Driver's License Number (optional):
NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and **Place of Birth**: [redacted]

8. Sex: [X] Male [ ] Female

9. Are you a U.S. citizen? [X] Yes [ ] No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? [X] Yes [ ] No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED: NOV 16, 1999 Eval. Status letter ATS # 7.2018

Pre-Medical Education

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
N/A		

Medical Education

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.
PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

L2 Trans

School Name	City, State, Country	Dates of Attendance	Degree Awarded
CHENGALPATTU MEDICAL COLLEGE	CHENGALPATTU, TAMILNADU, INDIA	08/1987 - 06/1992	04/1992
MADRAS UNIVERSITY			

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
CHENGALPATTU MEDICAL COLLEGE; MADRAS UNIVERSITY	CHENGALPATTU TAMIL NADU, INDIA	04/1992

* **MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**
Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY
School Code

L1A

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)	
USMLE - I	7/30/1998	[redacted]	☐
USMLE - II	4/23/1998	[redacted]	☐
USMLE - III	4/12/2004	[redacted]	☐

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
				☐
				☐
				☐
				☐

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No ☐

IF YES: PROFESSION: _____, LICENSE NO.: _____, JURISDICTION: _____.

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

☐ Yes ☒ No ☐

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance	
NY MEDICAL COLLEGE (R-0)	59-25, 153 St Jamaica, NY 11432	OB/GYN	07/2002 - 06/2005	☐
UPSTATE MEDICAL UNIV.	736 Irving Ave, Syracuse, NY	OB/GYN	07/2001 - 06/2002	☐
UMDNJ	Newark, NJ	OB/GYN	07/2000 - 06/2001	☐
				☐

QUESTIONS 16B through 23:

If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

☐ Yes ☒ No ☐

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A) ☒ Yes ☒ No ☐

17(B) ☒ Yes ☒ No ☐

17(C) ☒ Yes ☒ No ☐

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

☒ Yes ☒ No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

☒ Yes ☒ No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

☒ Yes ☒ No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

☒ Yes ☒ No ☐

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

☒ Yes ☒ No ☐

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23 (A) ☒ Yes ☒ No ☐

23 (B) ☒ Yes ☒ No ☐

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: VIKRAM KOTHANDARAMAN

DATE OF BIRTH: [redacted]

L1C

Top of Photo (Head)

Bottom of Photo (Shoulders)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF NEW YORK

COUNTY OF QUEENS

The applicant, VIKRAM KOTHANDARAMAN, [redacted], being first duly sworn
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

DEBRA COHEN
NOTARY PUBLIC, STATE OF NEW YORK
NO. 01CO6040720
QUALIFIED IN NASSAU COUNTY
MY COMMISSION EXPIRES AUG. 31, 2006

SIGNATURE OF APPLICANT Vikram Kothandaraman
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 16 day of January 2004
MONTH YEAR

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

70-02 Queens Blvd, Elmhurst NY
ADDRESS

My commission expires Aug [redacted], 2006

L1D

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that VIKRAM. S. KOTHANDARAMAN (FULL NAME OF APPLICANT); [redacted] (U.S. SOCIAL SECURITY NO.) (DATE OF BIRTH-MM/DD/YYYY)

enrolled in Chengalpattu Medical College (NAME OF MEDICAL SCHOOL), Chengalpattu (LOCATION)

on the 28th day of NOVEMBER (MONTH) 8, 1995 (YEAR) 1987 Per transcript and was granted the following credits on enrollment:

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

MEDICAL SCHOOL	TOTAL CREDITS	DATES
Chengalpattu Medical College	M.B.B.S.	28th Nov. 1995

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 5 ½ Years (NUMBER OF YEARS)

years of resident instruction of 275 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual

attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the _____ day of _____ (MONTH), _____ (YEAR) 11/28/95 Per diploma

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality as defined in Section 2090	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal or Partner Abuse Detection & Treatment**
Dermatology	Preventive medicine, including Nutrition	Family Medicine***
		Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998
**** Only applicable to medical students who enrolled in medical school on or after June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

Chingleput Medical College
Date 19-1-05
Chingleput

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this 19th day of Jan. (MONTH) 2005 (YEAR)

BY: _____ (PRESIDENT, DEAN, OR REGISTRAR)

L2

07A-100-L2 (Rev. 03-01)

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
Internet: www.medbd.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that WIKRAM SULTAN KOTHANDARAMAN [redacted] ; [redacted]
FULL NAME OF APPLICANT — U.S. SOCIAL SECURITY NO. — DATE OF BIRTH-MM/DD/YYYY

enrolled in Chengalpattu Medical College, Chengalpattu
NAME OF MEDICAL SCHOOL — LOCATION

on the 14 day of AUGUST, 1987 , _____ and was granted the following credits on enrollment:
MONTH — YEAR

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

Chengalpattu Medical College _____ _____
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4½ Years
NUMBER OF YEARS
years of resident instruction of 52 weeks each, completing at least 4,000 hours, of which at least 80 percent actual
NUMBER OF WEEKS
attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant :

☐ was granted the degree Bachelor/Doctor of Medicine by **OR** ☐ withdrew from

the above mentioned medical school on the 28 day of November , 1995 .
MONTH — YEAR

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality as defined in Section 2090	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemestry	Psychiatry	Pharmacology
Pathology, Bacteriology and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal or Partner Abuse Detection & Treatment**
Dermatology	Preventive medicine, including Nutrition	Family Medicine***
		Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
**** Only applicable to medical students who enrolled in medical school on or after June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

Chingleput Medical College
Date 3/5/05
Chingleput

ATTENTION MEDICAL SCHOOL : The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this Third day of May , 2005.
MONTH — YEAR

BY [signature] DEAN 02/05/05
PRESIDENT, DEAN OR REGISTRAR

Chengalpattu Medical College
Chengalpattu

L2

07A-100-L2 (Rev. 3/01)

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
KOTHANDARAMAN	VIKRAM	S

U.S. Social Security Number:	Date of Birth. MM/DD/YYYY	Telephone Number:
[redacted]	[redacted]	Home: [redacted] Work: [redacted]

Current Address: [redacted]

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

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! ***Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.*** **Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."**

Name of Facility:	Address of Facility:
UMDNJ - NEW JERSEY MEDICAL SCHOOL	DEPT. OB/GYN 185 SOUTH ORANGE AVE, MSB E-506 NEWARK, NJ 07103

Name of Program Director:	Telephone Number:
JACQUELYN S. LOUGHLIN, MD	(973) 972-5266

Signature of Program Director:	Date Signed:
[signature]	[illegible]

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
OBSTETRICS + GYNECOLOGY	7/1/2000	6/30/2001

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Stephen R. Baker, MD -Associate Dean for GME	UMDNJ-NEW JERSEY UNIVERSITY HOSPITAL/NJMS GRADUATE MED. ED.

Address of Facility:	
	30 BERGEN STREET, DMC 1107 NEWARK, NEW JERSEY 07107-3000
City / State / Zip Code	TELEPHONE: (973) 972-6048/49 FAX: (973) 972-2229

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education, it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education:	Date Signed:
[signature]	[illegible]

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
KOTHANDARAMAN	VIKRAM	S.

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number:
[redacted]	[redacted]	Home: ([redacted] Work: [redacted]

Current Address: [redacted] [redacted]

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

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! ***Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.*** **Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."**

Name of Facility:	Address of Facility:
New York Medical College, St Vincent Catholic Medical Center	[illegible] QUEENS HOSPITAL [illegible] QUEENS BLVD.

Name of Program Director:	Telephone Number:
[illegible], Chair, Program Director	(718) 558-1245

Signature of Program Director:	Date Signed:
[illegible]	3/24/05

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
PGY-3 OB/GYN	07/01/2002	06/30/2003

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

[illegible] 3/24/05

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
	NOTARY PUBLIC - STATE OF NEW YORK NO. 01CO6046750 QUALIFIED IN NASSAU COUNTY MY COMMISSION EXPIRES AUG. 21, 20[illegible]

Address of Facility:

City	State	Zip Code	Telephone Number:
			( )

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education:	Date Signed:

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
KOTHANDARAMAN	VIKRAM	S

U.S Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number:
[redacted]	[redacted]	Home: [redacted] Work: [redacted]

Current Address: [redacted]

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

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! ***Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.*** **Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."**

Name of Facility:	Address of Facility:
New York Medical College St Vincent Catholic Med. Center	[illegible] 90-02 QUEENS BLVD. [illegible]

Name of Program Director:	Telephone Number:
[illegible], Chair & Program Director	(718) 558-1245

Signature of Program Director:	Date Signed:
[signature]	3-24-05

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
PGY-4 OB/GYN	07/01/2004	Will be 06/30/2005

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

[signature] 3/24/05

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
JAHANGIR AYRUMLOOL, MD	NOTARY PUBLIC - STATE OF NEW YORK NO. 01CO6046753 QUALIFIED IN NASSAU COUNTY MY COMMISSION EXPIRES AUG. 21, 20[illegible]

Address of Facility:

City	State	Zip Code	Telephone Number:
			( )

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education:	Date Signed:

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
Internet: www.medbd.ca.gov

ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that VIKRAM KOTHANDARAMAN; [redacted]
(Name of Applicant) (U.S. Social Security Number)

[redacted] is in an approved ACGME/RCPSC postgraduate training position that
(Date of Birth -MM/DD/YYYY)

commenced on 07 / 01 / 2004 and is expected to be completed on
Month Day Year

06 / 30 / 2005 in Obstetrics & Gynecology
Month Day Year (Type of Training)

at St Vincent Catholic Medical
(Name and Address of Facility)
90-02 Queens Blvd, Elmhurst NY 11373

ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

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 RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or RCPSC program position.

JAHANGIR AYROMLOOI, MD
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

DEBRA COHEN
NOTARY PUBLIC - STATE OF NEW YORK
NO. 01CO[illegible]
QUALIFIED IN NASSAU COUNTY
MY COMMISSION EXPIRES AUG. 2[illegible], 2006

(Date) (Telephone Number)

Debra Cohen
Notary

OFFICIAL HOSPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

L4

07A-107-L4 (3/01)

GOVERNMENT CHENGALPATTU MEDICAL COLLEGE, CHENGALPATTU 603 001

(Directorate of Medical Education, Government of Tamil Nadu, India)

CLINICAL CLERKSHIP CERTIFICATE

Report of Clinical Rotations of I, II & III Clinical Years

This is to certify that **K. VIKRAM SULTAN** was a student of this college (Bachelor of Medicine and Bachelor of Surgery) during the period August 1987 – April 1992 and he participated in the clinical rotations of I, II and III Clinical years at the Chengalpattu Medical College Hospital. Chengalpattu 603 001 from the period of January 1989 to December 1991.

Date of Attendance		Clinical Discipline	Supervising Physician
I. Clinical Year (1989)			
1. Jan 1 – 20	1989	Clinical Pathology	Dr. Padmini Jayachandran, MD DCP
2. Jan 21 – Feb. 10	1989	Intensive Training (Surgery)	Dr. A. Sukumar, MS
3. Feb 10 – Feb. 28	1989	Intensive Training (Medicine)	Dr. John Vasegeran, MD
4. March & April	1989	Surgery	Dr. A. Sukumar, MS
5. June & July	1989	Obstetrics & Gynaecology	Dr. Shanmugapriya, MD DGO
6. Aug., Sep. & Oct. 1 – 15	1989	Medicine	Dr. John Vasegaran, MD
7. October 16 – 31	1989	Tuberculosis Clinic	Dr. Kannan, MD
8. November 1 – 15	1989	Dental Surgery	Dr. Radhakrishnan, MDS
9. November 16 – 30	1989	Radiology	Dr. Edwin Gurusamy, MD DMRD

Office Seal

Chengalpattu Medical College
Date 31/5/05
Chengalpattu

Dr. A.J. Balakrishna Rao. MD. FM.
Dean
Government Chengalpattu Medical College
Chengalpattu – 603 001
Tamil Nadu, India.

31/5/05 31/5/05

Date of Attendance	Clinical Discipline		Supervising Physician
II Clinical Year (1990)	Psychiatry		Dr. Arunagiri, MD DPM
1. Jan 1 – 15 1990	Family Planning & Psychiatry		Dr. Amudha Selvaraj, MD DGO
2. Jan 16 – 31 1990	Community Medicine Posting		Dr. K.C. Vishwanathan MD DCH
3. Feb 1 – 15 1990	Anesthesia		Dr. G.P. Venkatraman MD DA
4. Feb 16 – 28 1990	Dermatology		Dr. Rangarajan, MD
5. March 1990	Casualty		Dr. Ashraff M.B.B.S
6. April 1990			
7. June 1990	**7. am to – 10 a.m**	**10 a.m – 12 noon**	
	Outpatient Clinics	Monday – Plastic Surgery	Dr. Alalasundaram, MS MCh
		Tuesday – Community Medicine	Dr. K.C. Vishwanathan MD DCH
	Medicine (June 1 – 15)	Wednesday – Tuberculosis Clinic	Dr. Gowthaman M.S. DLO
	Surgery (June 16 – 30)	Thursday – Neurology	Dr. Velmurugan, MD DM
		Friday – Psychiatry	Dr. Arunagiri, MD DPM
		Saturday - Radiology	Dr. Edwin Gurusamy, MD DMRD
8. July 1990	Community Posting		Dr. K.C. Vishwanathan MD DCH
9. August 1990	Infectious diseases (Medicine)		Dr. G. Ramar, MD DM
10. Sep., Oct. & Nov 1990	Ophthamology (1½ months)		Dr. P. Balusamy, MS DO
	Otorhinolaryungology (1½ months)		Dr. K.M.C. subbupalaniyappan MS DLO

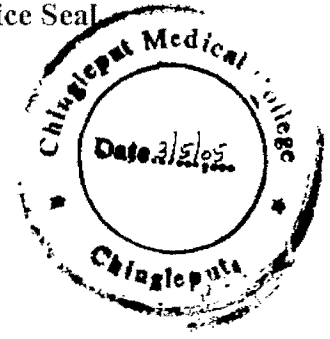
Office seal

Chingleput Medical College
Date. 31/5/95
Chingleput

Dr. A.J. Balakrishna Rao. MD. FM.
Dean
Government Chengalpattu Medical College
Chengalpattu – 603 001
Tamil Nadu, India.

Date of Attendance		Clinical Discipline	Supervising Physician
III Clinical Year (1991)			
1. Januvary & Februvary	1991	Obstetrics and Gynaecology	Dr. Shanmugapriya, MD DGO
2. March & April	1991	Surgery	Dr. J.R. Sadanandham, MS
3. June, July & Aug. 1-15	1991	Medicine	Dr. John Vasegaran, MD
4. Aug. 16-31 & Sep	1991	Orthopedics	Dr. Karthikeyan, MS DOrtho
5. October & Nov.	1991	Pediatrics	Dr. R.K. Sekar, MD

Office Seal



Dr. A.J. Balakrishna Rao. MD. FM.
Dean
Government Chengalpattu Medical College
Chengalpattu – 603 001
Tamil Nadu, India.

GOVERNMENT CHENGALPATTU MEDICAL COLLEGE, CHENGALPATTU 603 001

(Directorate of Medical Education, Government of Tamil Nadu, India)

CLINICAL CLERKSHIP CERTIFICATE

Report of Clinical Rotations of I,II & III Clinical Years

This is to certify that **K.VIKRAM SULTAN** was a student of this college (Bachelor of Medicine and Bachelor of Surgery) during the period August 1987 - April 1992 and he participated in the clinical rotaions of I,II and III Clinical years at the Chengalpattu Medical College Hospital. Chengalpattu 603 001 from the period of Januvary 1989 toDecember 1991.

Date of Attendance		Clinical Discipline	Supervising Physician
I Clinical Year (1989)			
1. Jan 1 - 20	1989	Clinical Pathology	Dr. Padmini Jayachandran, MD DCP
2. Jan 21 - Feb. 10	1989	Intensive Training (Surgery)	Dr. A. Sukumar, MS
3. Feb 10 - Feb. 28	1989	Intensive Training (Medicine)	Dr. John Vasegeran, MD
4. March & April	1989	Surgery	Dr. A. Sukumar, MS
5. June & July	1989	Onstetrics & Gynaecology	Dr. Shanmugapriya, MD DGO
6. Aug., Sep. & Oct. 1 - 15	1989	Medicine	Dr. John Vasegaran, MD
7. October 16 - 31	1989	Tuberculosis Clinic	Dr. Kannan, MD
8. November 1 - 15	1989	Dental Surgery	Dr. Radhakrishnan, MDS
9. November 16 - 30	1989	Radiology	Dr. Edwin Gurusamy, MD DMRD

Office Seal

MEDICAL COLLEGE CHINGLEPUT DATE 9/12/95

Chingleput Medical College Date 19-1-05 Chingleputs

I Attested I

Rewathi 19/1/05

DEAN
Chengalpattu Medical College
Chengalpattu

Dr. T.A. Thirumalai, M.D.D.A.,
Dean
Government Chengalpattu Medical College
Chengalpattu - 603 001
Tamil Nadu, India.

308

Date of Attendance	Clinical Discipline		Supervising Physician
II Clinical Year (1990)			
1. Jan. 1 - 15 1990	Psychiatry		Dr. Arunagiri, MD DPM
2. Jan. 16 - 31 1990	Family Planning		Dr. Amudha Selvaraj, MD DGO
3. Feb. 1- 15 1990	Community Medicine Posting		Dr. K.C. Vishwanathan MD DCH
4. Feb. 16 - 28 1990	Anesthesia		Dr. G.P. Venkatraman MD DA
5. March 1990	Dermatology		Dr. Rangarajan, MD
6. April 1990	Casualty		Dr. Ashraff M.B.B.S
7. June 1990	**7 a.m to - 10 a.m**	**10 a.m - 12 noon**	
	Outpatient Clinics Medicine (June 1-15) Surgery (June 16-30)	Monday-Plastic Surgery Tuesday-Community Medicine Wednesday-Tuberculosis Clinic Thursday-Neurology Friday-Psychiatry Saturday-Radiology	Dr. Alalasundaram, MS MCh Dr. K.C. Vishwanathan MD DCH Dr. Gowthaman M.S. DLO Dr. Velmurugan, MD DM Dr. Arunagiri, MD DPM Dr. Edwin Gurusamy, MD DMRD
8. July 1990	Community Posting		Dr. K.C. Vishwanathan MD DCH
9. August 1990	Infectious diseases (Medicine)		Dr. G. Ramar, MD DM
10. Sep., Oct. & Nov. 1990	Ophthalmology (1 1/2 months)		Dr. P. Balusamy, MS DO
	Otorhinolaryngology (1 1/2 months)		Dr. K.M.C. Subbupalaniyappan MS DLO

Office Seal

MEDICAL COLLEGE

Chingleput Medical College
Date..... 19-1-05
Chingleput

Attested
19/1/05
DEAN
Chengalpattu Medical College
Chengalpattu

Dr. T.A. Thirumalai, M.D.D.A.,
Dean
Government Chengalpattu Medical College
Chengalpattu - 603 001
Tamil Nadu, India.

Date of Attendance	Clinical Discipline	Supervising Psysician
III Clinical Year (1991)		
1. Januvary & Februvary 1991	Obstetrics and Gynaecology	Dr. Shanmugapriya, MD DGO
2. March & April 1991	Surgery	Dr. J.R. Sadanandham,MS
3. June, July & Aug. 1-15 1991	Medicine	Dr. John Vasegaran, MD
4. Aug. 16-31 & Sep. 1991	Orthopedics	Dr Karthikeyan, MS DOrtho
5. October 1991	Pediatrics	Dr. R.K. Sekar, MD

Office Seal

MEDICAL COLLEGE * DATE * CHINGLEPUT

Dr. T.A. Thirumalai, M.D.D.A.,
Dean
Government Chengalpattu Medical College
Chengalpattu - 603 001
Tamil Nadu, India.

Chingleput Medical College Date 19-1-05 Chingleput

| Attested |

DEAN
Chengalpattu Medical College
Chengalpattu

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/23/2007 **To Date:** 01/23/2007

ATRISUPPINF

27-MAY-11 14:32:38

Person Id : 1223939 **Name :** Kothandaraman,Vikram

Question	Answer
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.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	YES
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
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
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

Total Questions Asked For Person : 1223939 7

003263 134 63010100002 000918094 012209
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.

Health-Related Facility Name	Address

SMBCLS 02/28/05

RETURN THE ENTIRE PAGE TO THE ADDRESS ON THE BACK. MAKE A PHOTOCOPY FOR YOUR RECORDS.

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 Applicatio
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: Vikram S. DATE: 1/17/09

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.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/30/09
A 91809	02/28/09	$805.00	$885.50
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 805.00	$

ACTIVE VIKRAM S. KOTHANDARAMAN
725 S BIXEL STREET # 503B
LOS ANGELES CA 90017

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

OVER

63010100000100002000918094010228090008050000088550

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 02/01/2011 **To Date:** 02/01/2011

ATRISUPPINF

27-MAY-11 13:40:49

Person Id : 1223939 **Name :** Kothandaraman,Vikram

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.	YES
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 : 1223939 8