



MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION SSN= 218588026

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY THAT I DO MEET EACH OF THE 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.

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

G. LICENSE NO. 40829 EXPIRES 09/30/05

Table with FEE OWED (\$600.00) and DELINQ FEE IF POSTMARKED AFTER 10/30/05 (\$660.00)

ACTIVE GEORGE YUNG KUNG 120 CRAVIN RD STE 209 SAN MARCOS CA 92069

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

Vertical barcode/ID number on the right edge of the page.

004607 11 6301070006 000408294 062005
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
39 600.00	
CONSUMER AFFAIRS	



MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

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

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

LICENSE NO. 40829
EXPIRES 09/30/07

TOTAL ENCLOSED \$
VOLUNTARY FEE \$
ACTIVE GEORGE YUNG KUNG
120 CRAVIN RD STE 209
SAN MARCOS CA 92069

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SIGNATURE REQUIRED HERE: *[Signature]* DATE: 6/15/07

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 10/30/07
\$805.00	\$885.50
\$	\$

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] Signature required here

001170 149 63010700006 000408294 062207
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CON

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Health-Related Facility Address
NAME: HILF AIRS

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

**License Renewal Application
Physician and Surgeon**

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. YES NO

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

AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 10/30/09
\$808.00	\$886.00
\$	\$

E. FOR ADDRESS CHANGE ONLY
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STREET _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER () _____

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[Signature]
Signature required here

LICENSE NO. **6 40829** EXPIRES **09/30/09**
VOLUNTARY FEE = \$
TOTAL ENCLOSED = \$
ACTIVE GEORGE YUNG KUNG
120 CRAVIN RD STE 209
SAN MARCOS CA 92069

OVER

63010700000700006000408294010930090008080000088600

001983 36 63010700006 000408294 070609
 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

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Health-Related Facility Name	Address
15 508 00	CONSUMER AFFAIRS

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

License Renewal Application
Physician and Surgeon

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 YES NO

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

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SIGNATURE REQUIRED HERE: [Signature] DATE: 7/1/11

AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 10/30/11
\$ 808.00	\$ 886.00
VOLUNTARY FEE = \$	
TOTAL ENCLOSED = \$	

LICENSE NO. 6 40829 EXPIRES 09/30/11
ACTIVE GEORGE YUNG KUNG
120 CRAVIN RD STE 209
SAN-MARCOS CA 92069

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PHONE NUMBER () _____

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[Signature] Signature Required Here

OVER

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Health-Related Facility Name	Address
21 808 00 CONSUMER AFFAIRS	

002480 140 63010700006 000408294 071211
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER

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