STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

002030

RONALD REAGAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS
1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE:
Applications and Examinations (916) 322-5040

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
JUL 2 3 32 PM '75

0376
0376
03764

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

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

1. NAME: Last	First	Middle	Maiden	2. Social Security No.:
RIOS	FELICIANO	R.	—	[redacted]

3. List other names, if any, you have used:

4. Address: Street and No./Rural Route	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]

5. Name you wish on License: FELICIANO R RIOS

Birthdate: (Month - Day - Year) [redacted]

6. Premedical Education: Name of College or University: LEE JR COLLEGE, UNIVERSITY OF HOUSTON
Location: BAYTOWN, TEXAS; HOUSTON, TEXAS
Period of attendance: From: JUN 64 SEPT 65 To: AUG 65 JUN 68
Check premed courses successfully completed: ☐ Chemistry ☐ Physics ☑ Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	UCLA SCHOOL OF MEDICINE	LOS ANGELES	SEPT 70	JUN 71
2nd	UCLA SCHOOL OF MEDICINE	LOS ANGELES	SEPT 71	JUN 72
3rd	UCLA SCHOOL OF MEDICINE	LOS ANGELES	JUN 72	JUN 73
4th	UCLA SCHOOL OF MEDICINE	LOS ANGELES	SEPT 73	JUN 74
5th				
6th				

8. Doctor of Medicine Degree granted by: UCLA SCHOOL OF MEDICINE - Date: JUN '74
For office use only School Code: CA 14

9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
BEXAR COUNTY HOSPITAL DISTRICT	STRAIGHT OB-GYN	JUN 28, 74	JUN 27, 75

10. List all States in which you have been licensed to practice medicine: -0-

11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? ☐ Yes ☑ No

If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? ☐ Yes ☑ No

If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

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

FORM 07A-161 (REV. 7/8)

(Over)

14. Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics or to drug addiction?	Yes [redacted]	No [redacted]
15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)	Yes [redacted]	No [redacted]

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

Violation and Location	Date	Penalty/Disposition

[redacted]

Applicant: Please complete the following:

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

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

Identifying marks: [redacted]

NT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant Alicia Ann

Date 6/21/76

Subscribed and sworn to before me this 21st day of June 1976.

Signature of Notary Stella L. Trevino

SEAL

Address 4502 Medical Dr.
San Antonio, Texas

My commission expires: June 77

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

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

CERTIFICATE OF EDUCATION

This Certifies That Feliciano Rios, M.D.
Full name of applicant

enrolled in UCLA School of Medicine
Name of medical school (college)

on the 28 day of Sept. 19 70
Month Year

☒ as a Freshman,

☐ with advanced standing based on _____
Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

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

at U. Houston, and that he attended while at this
Please indicate school

medical school (college) 40 courses of lectures of _____ weeks each,
Specify number Specify number of weeks

completing 5259 hours in the subjects below listed, and that he/she:
Total hours

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

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

_____

_____

on the 14 day of June 19 74
Month Year

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

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

*included in Gen. Med. & Surg. cours

Signed and the College seal affixed this 2 day
of Sept. 19 75
Month Year

[Affix Seal Here]

By _____
President, Secretary, Dean

07A-32 (REV. 8-74)

002569 B4 63010700006 000332726 010307
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
NONE 805 00	

SMBCLS 02 28 07

PART 3

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION PHYSICIAN AND SURGEON

State of California Department of Consumer Affairs

SSN= [redacted]

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: [signature] DATE 12-28-06

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

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

	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/02/07
	$805.00	$885.50
VOLUNTARY FEE =	$	$
TOTAL ENCLOSED =	$	$

LICENSE NO. G 33272

EXPIRES 01/31/07

ACTIVE FELICIANO R. RIOS
1079 C 3RD AVE
CHULA VISTA CA 92011

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, HAVE NO FINANCIAL INTEREST TO DISCLOSE.

[signature] Signature required here

630107000007000060003327260101310700080500000885 50

000176 87 63010700006 000332726 111408
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS 805.00

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
NONE	

SMBCLS 02/28/05

PART 3

STATE OF CALIFORNIA
dca
DEPARTMENT OF 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

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SIGNATURE REQUIRED HERE [signature] DATE: 10/24/08

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/02/09
G 33272	01/31/09	$805.00	$885.50
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 805.00	$

ACTIVE FELICIANO R. RIOS
1079 C 3RD AVE
CHULA VISTA CA 92011

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 [signature]

630107000007000060003327260101310900080500000088550

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/19/2011 **To Date:** 01/19/2011

ATRISUPPINF

30-AUG-12 08:40:19

Person Id : 586175 **Name :** Rios,Feliciano

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	YES

Total Questions Asked For Person : 586175 8